IN THE MATTER OF	*	BEFORE THE
NANCY D. BRAUER, P.T.	*	MARYLAND STATE
License No. 15691	*	BOARD OF PHYSICAL THERAPY
	*	EXAMINERS
	*	Case No. 05-10C

* * * * * * * * * * *

FINAL ORDER AND RULINGS ON POST-HEARING MOTIONS

Procedural History

This case arose from allegations that Nancy D. Brauer, P.T. (the "Respondent"), License Number 15691, failed to inform the Board of Physical Therapy Examiners regarding certain illegal and fraudulent practices at Associated Therapy Specialists, Inc. ("ATS") for which the Respondent practiced on a contractual basis. Specifically, the Board investigated ATS based on information that unlicensed personnel, some of whom were minors, were creating false treatment notes; and that the owner of ATS, Frederick Cudlipp, submitted false billings, engaged in sexual misconduct with a patient, and failed to cooperate with the Board's investigation.[1] The Respondent was subsequently charged on January 17, 2006, for failing to notify the Board of the illegal practices at ATS and for failing to adhere to standards of practice in delivering physical therapy care. Based on this information and pursuant to its authority under the Maryland Physical Therapy Act, Md. Code Ann., Health Occ. ("H.O.") §13-101 *et seq.* (the "Practice Act"), the Board of Physical Therapy Examiners (the "Board") charged the Respondent with violating H.O. §13-316, which provides in relevant part:

[1] The Board issued a Final Order against Mr. Cudlipp based on the above allegations, on November 15, 2005, which revoked Mr. Cudlipp's license.

Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee or holder:

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

(25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy care.[2]

The Board further charged the Respondent with the following violations of the Code of Maryland Regulations (COMAR), Title 10:

§ 38.02.01 – Code of Ethics

F. The physical therapist and physical therapist assistant shall report to the Board of Physical Therapy Examiners all information that indicates a person is allegedly performing, or aiding and abetting, the illegal or unsafe practice of physical therapy.

§ 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.

A two-day hearing on the merits was held on April 20 and 27, 2006, before a Hearing Committee of the Board (the "Committee"), pursuant to Health Occ. § 13-317(d). On August 4, 2006, the Committee issued a Proposed Decision ("Proposed Decision") wherein it concluded that there was sufficient evidence to prove that the Respondent violated H.O. §13-316(16) and (25), and COMAR 10.38.03.02A(2)(a);

[2] The Board's charging document contained a typographical error citing Section 13-313(25) instead of Section 13-313(26), although the text and content of the statute, as referenced in the charging document, is correct.

however, the Committee found insufficient evidence to affirm the Board's charge under COMAR 10.38.02.01F. Thus, the Committee recommended that the charges against the Respondent be affirmed, with the exception of COMAR 10.38.02.01F.[3]

Contemporaneous with the issuance of the Proposed Decision, the Board's Executive Director informed the parties of the right to file exceptions before the full Board. The Respondent filed exceptions on August 25, 2006. The State filed a Response to the Respondent's exceptions on September 11, 2006. Prior to the hearing on exceptions and in addition to the exceptions filed by the Respondent, the Respondent filed eight (8) Motions. Specifically, the Respondent filed the following Motions prior to the Board's hearing on exceptions:

(1) Motion to Dismiss Charges Due to the Board's Consideration of Documents Not Entered Into Evidence;

(2) Second Motion to Dismiss Charges Due to the Board's Consideration of Documents Not Entered Into Evidence;

(3) Motion to Dismiss Charges Due to the Board's Ex Parte Communications;

(4) Motion to Dismiss Charges Due to the Board's Violation of the Respondent's Rights to Due Process;

(5) Motion to Dismiss Charges Due to the Board's Shifting of the Burden of Proof to the Respondent;

(6) Motion to Dismiss Charges Due to the Failure of the State to Present Any Evidence that a Physical Therapist Who Treated a Patient Without Reviewing Treatment Notes Breached the Standard of Care;

(7) Motion to Dismiss Charges Due to the Board's Failure to Timely Issue its Proposed Decision; and

(8) Motion to Stay Execution Pending Appeal.

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[3] The Committee's decision was due to be issued on July 26, 2006. However, the Board granted the Committee an extension until August 4, 2006, in accordance with COMAR 10.38.05.05F(3).

On October 17, 2006, the parties appeared before a quorum of the Board for a hearing on the exceptions.[4] On that same date, October 17, 2006, the Board convened for a final decision in this case. Subsequently, after the exceptions hearing and after the record had been closed in this matter, the Respondent filed a Motion to Dismiss Charges Due to the State's Withholding of Exculpatory Evidence on November 21, 2006. The Board's ruling on all of the above Motions follow the final decision in this matter.

SUMMARY OF THE EVIDENCE

The Board adopts and incorporates by reference the proposed Summary of Exhibits and Pertinent Witness Testimony made by the Committee in the Proposed Decision issued on August 4, 2006, as the Board's final Summary of the Evidence. The entire Proposed Decision is attached hereto as Appendix A.

FINDINGS OF FACT

The Board adopts and incorporates by reference certain proposed Findings of Fact made by the Committee in the Proposed Decision issued on August 4, 2006, as the Board's final Findings of Fact and modifies others. The Findings of Fact have been reproduced in whole below.

1. At all times relevant, the Respondent was a licensed physical therapist in the State of Maryland. The Respondent was originally licensed on October 19, 1984. From 1993 through October 2004, the Respondent was contractually employed as a physical therapist ("P.T.") at Associated Therapy Specialists, Inc., ("ATS") located at 4014 Mountvale Road, Jefferson, Maryland, by Frederick Cudlipp, P.T., who then owned ATS.

[4] Although the Respondent was represented during the two-day evidentiary hearing by her husband, John J. O'Donnell, Esquire, admitted to practice in Maryland *pro hac vice,* Mr. O'Donnell withdrew his appearance prior to

[T. 222]

2. While employed at ATS, the Respondent worked part-time, covering for Mr. Cudlipp when he was not in the office. [State's Ex. 2, T. 20] The Respondent was the only licensed staff working at ATS during the hours that she worked. [State's Ex. 3]

3. The Board received a complaint from a woman stating that her daughter was employed at ATS and was being directed to create patient treatment notes. The Board's subsequent investigation into the matter resulted in an Order of Revocation against Frederick Cudlipp, P.T., the owner of ATS, effective November 15, 2005. (State's Ex. 1).

4. The Board subsequently issued charges against the Respondent on January 17, 2006.

5. As part of its investigation, the Board's investigator interviewed, under oath, the Respondent and several unlicensed personnel at ATS. [T. 44-45]; (State's Ex. 2)

6. During the interviews of the unlicensed personnel, the interviewees indicated that they were instructed by Mr. Cudlipp to create patient treatment notes using "cheat sheets". "Cheat sheets" were codes developed by Mr. Cudlipp that were paired with narrative statements detailing physical therapy procedures and patient responses to procedures. (State's Ex. 10, Bates 38-41)

7. The Respondent was aware that ATS used "cheat sheets" to do patient treatment notes, but believed they were used as short cuts for objective narratives. [T. 250-51]

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the exceptions hearing and the Respondent appeared *pro se*.

8. The Respondent did not utilize Mr. Cudlipp's cheat sheets in writing her treatment notes, but did use her own system of short cuts in completing her treatment documentation. The Respondent did not, however, produce any documentary evidence that indicated how her system of short cuts differed from that of Mr. Cudlipp. [T. 252]

9. ATS was a busy physical therapy practice, requiring the Respondent to treat up to15-18 patients per day. (e.g., State's Ex. 3, Bates 9, 10, 86, 99, 104, 107)

10. The Respondent was given summaries written by Mr. Cudlipp regarding the patients' treatment. The summaries were kept with the patients charts. The summaries were at times very brief and did not contain the requisite clinical information upon which a physical therapist could commence treatment on patient. (State's Ex. 3)

11. The patients' charts included primarily insurance and billing information such as billing summary of services, fee sheets, patient intakes, medical prescriptions, phone communications with insurance providers, and utilization and review requests. Occasionally, there may be a treatment note included among the administrative forms. (Resp's Ex. 18)

12. The information contained in the insurance and billing documents did not present a comprehensive medical picture of the patient's care.

13. The practice at ATS was to keep treatment notes written by Mr. Cudlipp and the contractual, visiting physical therapists in a "notebook", and not in the patients' charts. Although the notebook was referred to by the Respondent and other employees of

ATS, it was never located. [T. 64]

14. ATS kept a separate set of treatment notes by Mr. Cudlipp and the contractual physical therapists on "100's" of computer discs. The discs were organized week by week and with all patient information compiled together according to treatment dates. [T. 235]

15. The Respondent generally did not review patient evaluations unless the patients were recent patients. In fact, the Respondent stated that Mr. Cudlipp's summaries were more appropriate than reviewing actual treatment notes unless the patient was only on his second or third visit. (State's Ex. 2, p. 21-22)

16. The Respondent did not review patient treatment notes routinely as part of her treatment of patients at ATS. [T. 226, 277]

17. The Respondent's heavy patient load of up to 15-18 patients per day would not have allowed her time to search the 100's of computer discs and notebooks to review treatment notes for every patient.

18. The Respondent would have long lapses in her work attendance at ATS. For example, the Respondent worked on March 6-7, 2003, and then did not return again until September 17, 2003. (State's Ex. 4)

19. The Respondent completed fee sheets after performing treatment on patients. The Respondent frequently did not circle or otherwise indicate the number of units of

each procedure for which to bill. "Units" refer to intervals of 15 minutes of one-on one, patient-to-physical therapist treatment. [State's Ex. 2, T. 31]

20. The Respondent's fee sheets were then altered and upcoded after the Respondent had submitted them to the office staff. For example, the fee sheet for Patient BW, dated March 17, 2004, was changed to delete the codes for hot packs, electrical stimulation, ultrasound, and soft tissue release. Instead, it appears that two units of therapeutic exercise, one unit of myofascial technique, and one unit of joint mobilization were added. The altered bill resulted in an increased fee. (State's Ex. 6); [T. 199]

21. The procedures that were added to the altered bill required direct one-to-one contact between the physical therapist and the patient. It is highly unlikely that the Respondent could have rendered the direct one-to-one treatment reflected on the altered fee sheet based on her busy patient load. [T. 156]

22. The Respondent was not aware that her fee sheets were being altered. However, when questioned regarding the altered bills, the Respondent failed to appreciate that the alterations resulted in fraudulent billing. The Respondent did not have access to her treatment notes when questioned regarding the altered fee sheets. (State's Ex. 2, pp. 36-44)

OPINION

The Board modifies the Committee's proposed Opinion in the Proposed Decision, dated August 4, 2006, as set forth below.

The Respondent made numerous exceptions to the Committee's Proposed

Decision, stating that many of the Committee's findings were not supported by "any evidence or testimony whatsoever" and that the Committee's Proposed Decision was "copied and pasted" directly from the State's closing argument. On the contrary, the Board finds that the Committee's Proposed Decision was supported by reliable and credible evidence in the record. That the Respondent disagrees with the Committee's evaluation of the evidence does not render the Committee's Proposed Decision invalid or baseless. That the State's closing argument summarized evidence in the record that was eventually relied upon by the Committee in rendering its Proposed Decision does not indicate that the Committee "copied and pasted" anything. In fact, even a cursory reading of the two indicates otherwise.

The evidence in the record clearly indicates that the Respondent did not, as a part of her regular practice at ATS, review treatment notes of patients for whom she was rendering physical therapy services. Instead, the Respondent testified that she relied upon "beautifully and extensively written summaries" by Mr. Cudlipp. [State's Ex. 2, T. 20] and interviews with the patients. [T. 226] *If* the summaries did not provide the Respondent with adequate information, then she would retrieve additional information from the insurance documentation in the patients' charts. [T. 226]

The Board finds the Respondent's description is not a fair or accurate depiction of the summaries. The summaries upon which the Respondent relied were brief and wholly inadequate in terms of clinical documentation and did not come close to complying with the Board's regulatory requirements for treatment documentation. The Board's regulations, during the period at issue, required that every treatment note contain the following information:

1. Date;
2. Cancellation, no-shows;
3. Subjective response to previous treatment;
4. Modalities, or procedures, or both, with any changes in the parameters involved and areas of the body treated;

5. Objective functional status;
6. Response to current treatment;
7. Continuation of or changes in the plan of care;
8. Signature, title (PT), and license number.

The Board finds that these brief summaries were an inadequate substitute for actual clinical documentation, and in some cases provided absolutely no useful clinical information. [e.g., State's Ex. 2, Bates 16, 43, 974-6]

In addition, the Respondent testified that she utilized the insurance information in the patient's chart. Unlike the standard practice, the patients' charts did not contain treatment documentation, but rather insurance reimbursement information. The Respondent asserted that the information contained in the insurance documents was an appropriate substitute for information that would be provided in a treatment note. The Board disagrees. First, insurance documentation is written for a completely different goal, to obtain reimbursement. Second, insurance documentation only addresses covered activities and procedures. Treatment notes, clinical evaluations and reevaluations, on the other hand, are written to provide subsequent healthcare professionals with appropriate medical information to provide beneficial physical therapy care.

For example, the insurance information in the patient chart for L.G.[5] contained pain level measurements with numerical ratings and did not include specific measurable data to include frequency, duration, quality of pain and types of activities that increase or decrease the intensity. In addition, the range of motion tests were not specific and measurable based on standard goniometric tests, i.e., does not indicate the range for all motion – flexion, extension, rotation, lateral flexion in the neck. Furthermore, the goals were not specific, measurable, reasonable or time-based. The goals did not indicate the short-term goals, or the length of time needed to achieve the goal.

Lastly, although the Respondent made much of the fact that she interviewed every

[5] The Proposed Decision contained a typographical error in its reference to this patient's chart. The patient initials for D.B. were inadvertently referenced instead of patient L.G. All issues with respect to this patient's chart remain the same.

patient prior to treatment, interviews with patients were required under the law in order to obtain current subjective information, in conjunction with the review of treatment records. However, the Respondent should not rely on patient interviews in lieu of reviewing actual treatment notes. As the healthcare professional, it is incumbent upon the Respondent to review treatment records and apply her physical therapy expertise accordingly, and not shift the responsibility to the patient to furnish her with information she should have had by reviewing treatment notes.

Daily treatment notes are required under the law to insure that patients receive a continuum of quality physical therapy services. To eschew the regulatory requirements in favor of brief summaries and insurance information undermines the purpose of the documentation requirements and jeopardizes the health and safety of Maryland citizens. In the Respondent's case, use of the treatment notes was particularly in order since the Respondent would go for long periods of time in which she did not work at ATS. For example, the Respondent worked at ATS in March 2003 and did not return again until September 2003. Because of her sporadic attendance at ATS, it was imperative that the Respondent review the treatment records of every patient when rendering physical therapy services. Doing otherwise resulted in the cursory treatment of patients under her care.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact and Opinion, and after consideration of the hearing record, the Respondent's exceptions, the State's responses thereto, the Respondent's Motions, and any State's responses thereto, the Board finds that the Respondent violated Md. Code Ann., Health Occ. §13-316(16) and (26), and Code Md. Regs. tit. 10, § 38.03.02A(2)(a). The Board affirms the dismissal of Code Md. Regs. tit. 10, §38.02.01F.

SANCTIONS

For the reasons set forth in the Opinion above, the Board sanctions the Respondent with a suspension of six (6) months, all stayed, probation for two (2) years, and a fine of $1,500. The Board has serious concerns that an experienced physical therapist such as the Respondent would engage in such a deficient practice at ATS for such an extended period of time. Furthermore, the Respondent continues to assert that such practice was proper and enabled the provision of adequate physical therapy care despite the testimony and documentary evidence that indicate the contrary. The Respondent refuses to accept any accountability for her actions, and instead has blamed everyone else - the Board, the Hearing Committee, the Administrative Prosecutor, the investigator, and Mr. Cudlipp - for her current predicament. The Board feels that this sanction is necessary to address the violations committed by the Respondent as well as to provide a deterrent to other physical therapists who may be tempted to abdicate their professional responsibilities in rendering physical therapy care.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this day of 16 January, 2007, by a majority of the full authorized membership of the Board considering this case, that under the authority of Health Occupations Article, §13-316, it is hereby

ORDERED that the license to practice physical therapy held by the Respondent, NANCY BRAUER, is SUSPENDED for six (6) months, ALL STAYED; and be it further,

ORDERED that the Respondent shall be placed on PROBATION for at least two (2) years, during which the Respondent shall:

1. Successfully complete a Board-approved record-keeping/documentation

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1. Successfully complete a Board-approved record-keeping/documentation

course within the first year of probation; and

2. Successfully complete a Board-approved billing and reimbursement course within the first year of probation;

3. Successfully complete a Board-approved ethics course within the first year of probation; and

4. Submit to the Board any automated documentation system for approval prior to utilization; and be it further,

ORDERED that the Respondent shall pay a fine in the amount of $1,500 within six (6) months of the date of this Order; and be it further,

ORDERED that this is a Final Order of the Maryland Board of Physical Therapy Examiners and as such is a PUBLIC DOCUMENT pursuant to *Md. Code Ann.*, State Gov't §§ 10-611 *et seq.*

January 16, 2007
Date

Stephen Ryan, P.T.
Stephen Ryan, P.T.
Board Member, Presiding Officer

NOTICE OF RIGHT TO APPEAL

Pursuant to Md. Code Ann., Health Occ. §13-318, you have a right to take a direct judicial appeal. A petition for appeal shall be filed within thirty days of your receipt of this Final Order and shall be made a provided for judicial review of a final decision in the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't §§10-201 et seq., and Title 7, Chapter 200 of the Maryland Rules.

BOARD'S RULINGS ON MOTIONS

1. Motion to Dismiss Charges Due to the Board's Violation of the Respondent's Rights to Due Process

There were several arguments raised in this Motion. The Board will address each one in turn below.

The Board's Charging Document Did Not Contain Sufficient Notice that the Respondent Violated the Standard of Care in Not Reviewing Treatment Documentation

The Board's charging document set forth 15 allegations of fact detailing the specific nature of the alleged violations. Allegations numbered 10 and 12 specifically reference that the Respondent failed to utilize treatment notes when rendering physical therapy treatment. This provided Respondent with sufficient notice of the allegations against her pursuant to the Administrative Procedure Act, *Md. Code Ann.,* State Gov't § 10-207; *see also Regan v. Board of Chiropractic Examiners,* 120 Md.App. 494 (1998). After a two-day evidentiary hearing, and an exceptions hearing, the Board's decision affirmed certain allegations contained in the charges related to the Respondent's failure to review treatment notes. These findings are based upon reliable and credible evidence in the record.

The Hearing Committee Improperly Considered the State's Expert's Testimony

The Hearing Committee properly considered the State's expert's testimony that use of summaries in lieu of reviewing actual treatment documentation was a violation of the standard of care. The State's expert report, provided to the Respondent during

discovery, contained the same proposition. In fact, the expert's opinion was based on the Respondent's assertions under oath that the summaries were "beautifully written". Notwithstanding the Respondent's much-inflated portrayal of the summaries, the expert opined that use of such summaries in lieu of actual treatment notes violated the standard of care. The expert's review of the actual summaries utilized by the Respondent did not alter her original opinion. Lastly, the Respondent failed to timely object to the expert's review of the summaries and therefore, waived any objection to the expert's testimony in this regard.

The Board violated Respondent's Due Process by Performing Both Investigatory and Adjudicative Functions and by Utilizing the Attorney General's Office for legal counsel and to Prosecute This Matter

The Board's performance of both investigative and adjudicative functions does not violate due process in accordance with the seminal case of *Withrow v. Larkin,* 421 U.S. 35 (1975). *Withrow* and its progeny set forth the proposition that administrative agencies may function in both capacities and are presumed to do so with honesty and integrity. In addition, the Board's use of the Attorney General's Office to act as both a legal advisor and prosecutor does not violate due process. In fact, the Board's regulations, COMAR 10.38.05.05C, specifically provide that the Board may request that representatives of the Office of the Attorney General act in these capacities.

The Board Erred in Quashing the Respondent's Subpoena for Donald Novak

The Board properly quashed the subpoena for Donald Novak. The Respondent proffered that the purpose of Donald Novak's testimony was to establish that Mr. Novak, a current board member, performed a two-month due diligence assessment of ATS, and

subsequently decided to purchase the practice. The focus of due diligence is financial. The purpose is to assess referral sources and accounts receivable to determine whether the business is a good investment. The fact that Mr. Novak opted to purchase ATS based upon his due diligence assessment has absolutely no relevance to the issue of whether the Respondent adhered to the standards of care in rendering physical therapy services. In addition, the charged allegation that was even remotely connected to Mr. Novak's involvement with ATS, i.e., the Respondent's knowledge that illegal activities were taking place at ATS and her failure to report them, was dismissed by the Board. Therefore, assuming *arguendo* that Mr. Novak's testimony was relevant to address the allegation that Respondent knew that illegal activities were taking place at ATS, the issue is moot as the Board dismissed this charge based upon the recommendation of the Hearing Committee.

The Respondent's Due Process Rights were Violated Because the Hearing Committee Issued its Proposed Decision After the Regulatory Deadline

The Board granted the Hearing Committee an extension to issue its Proposed Decision, in accordance with COMAR 10.38.05.05F(3), and thus, the Proposed Decision was not untimely issued. In addition, even if the Board had not granted an extension, the Proposed Decision would still have been valid and enforceable. The Board's regulations do not contain a sanction for failure to issue a proposed decision within 90 days, thus indicating that the regulation is directory and not mandatory. *See Solomon v. Board of Physical Quality Assurance,* 132 Md. App. 447, 457 (2000); *see also Salisbury Beauty Schools v. State Board of Cosmetologists,* 268 Md. 65 (1973).

The Board's Sanction is Arbitrary and Capricious

The Board's sanction is not arbitrary or capricious. In fact, the Board actually lessened the sanction that was originally recommended by the Hearing Committee. Notwithstanding that, the Board has the authority to apply its expertise in evaluating the evidence and determining an appropriate sanction. The Board's sanction in this case is appropriate given the nature of the violations, the duration that the Respondent engaged in the violations, and the Respondent's lack of remorse or ability to accept responsibility for the misconduct.

MOTION DENIED.

2. Motion to Dismiss Charges Due to Board's Shifting of the Burden of Proof to the Respondent

The Respondent offers absolutely no evidence that the Hearing Committee shifted the burden of proof to the Respondent. In fact, the Hearing Committee dismissed the allegation that the Respondent knew of illegal activities and failed to report them because it was not proven *by a preponderance of the evidence.* (Proposed Decision, p.11) In addition, the Presiding Officer indicated at the hearing that the State had the burden of proving the case by a preponderance of the evidence. [T. 7]

MOTION DENIED.

3. Motion to Dismiss Charges Due to the Failure of the State to Present Any Evidence that a Physical Therapist Who Treated a Patient Without Reviewing Treatment Notes Breached the Standard of Care

The Board was presented with substantial evidence indicating that the Respondent failed to review treatment notes routinely in her treatment of patients at ATS. The State's

expert clearly testified that such practice was against the appropriate standard of care. The Board members also have the authority to utilize their expertise in their evaluation of the evidence and determine the appropriate standard of care. *Md. Code Ann.,* State Gov't § 10-213(i). In this matter, the Board concurred with the State's expert that a physical therapist who routinely treats patients without reviewing treatment notes does not exercise sound professional judgment and violates the standard of care.

MOTION DENIED.

4. Motion to Dismiss Charges Due to the Board's Failure to Timely Issue Its Proposed Decision

MOTION DENIED. (See discussion under No. 1)

5. Motion to Stay Execution of License Suspension and Period of Probation Pending Appeal

This Motion is moot since it was filed as a result of the issuance of the Hearing Committee's Proposed Decision. The Proposed Decision is not considered a final order, providing the parties with an opportunity to file exceptions. The sanction recommended in the Proposed Decision was not in effect pending the issuance of a final order in this matter.

MOTION DENIED.

6. Motion to Dismiss Charges Due to the Board's Consideration of Documents Not Entered Into Evidence

The Respondent filed this Motion based on an erroneous assumption that the Committee relied on documents not in evidence when it referred to pain level measurements and other information in the patient chart for D.B. As stated in the

Discussion above, the Committee merely referenced the wrong patient file. The correct reference is to the patient L.G.'s file, in which the insurance documentation containing numerical pain levels, etc., is insufficient to substitute for actual clinical documentation.

MOTION DENIED.

7. Second Motion to Dismiss Charges Due to the Board's Consideration of Documents Not Entered Into Evidence

The Respondent again assumed that the Committee relied upon evidence outside the record because it found that the Respondent treated *an average* of 15-18 patients per day. Based on the exceptions filed by the Respondent, the Board corrected that finding by stating that the Respondent treated *up to* 15-18 patients per day, as evidenced in State's Exhibit 3, the same exhibit referenced in the Committee's Proposed Decision.

MOTION DENIED.

8. Motion to Dismiss Charges Due to the Board's Ex Parte Communications

The Respondent presented no evidence that the Committee engaged in *ex parte* communication with the Administrative Prosecutor. The Board denies and rejects such a baseless assertion.

MOTION DENIED.

9. Motion to Dismiss Charges Due to the State's Withholding of Exculpatory Evidence

The Respondent argues that the Administrative Prosecutor in this matter withheld exculpatory evidence, that is, transcripts of interviews conducted by the Board's investigator with Donald and Rosina Novak during the Board's investigation of Mr. Cudlipp.

First, the Board does not find that this evidence is exculpatory, and in fact, as evidenced by the Committee's ruling in limine, finds this evidence to be irrelevant. The Board had the opportunity to review these transcripts in voting to charge the Cudlipp matter, the instant matter against the Respondent, as well as two other related matters. Thus, the Board is familiar with the transcripts and its contents and does not find that anything stated in the Novaks' interviews were relevant to the Respondent's case. The Novaks engaged in a two-month due diligence exercise of Mr. Cudlipp's practice. As stated above, due diligence focuses on financial matters by reviewing accounts receivable and referral sources. The fact that the Novaks reviewed patient records and subsequently determined to purchase the practice in no way acts as an endorsement of the manner in which Mr. Cudlipp was operating the practice. In any event, the Novaks financial decision to purchase Mr. Cudlipp's physical therapy practice is completely irrelevant to the issue of whether the Respondent, who worked there for twelve years, had knowledge of illegal activities and engaged in deficient standards of practice.

Secondly, the Board finds this issue to be moot since the Board dismissed the charges to which the Respondent asserts the Novaks' testimony would have been relevant. The Board dismissed the charges that the Respondent failed to report her knowledge of alleged illegal activities which were taking place at ATS. The Respondent contends that the transcripts evidence that the Novaks' reviewed ATS's patient records and did not find anything amiss, and therefore, the Respondent should similarly not have been expected to have been cognizant of any illegal activity. Notwithstanding that the Novaks' focus during their due diligence was not treatment oriented, but financial, and

that the Novaks reviewed documentation over two months while the Respondent worked at ATS for 12 years, the Board determines that this issue is moot since the charges in this regard were dismissed.

MOTION DENIED.