IN THE MATTER OF	*	**BEFORE THE MARYLAND**
TANYA HEGE-MAISEL P.T.	*	**STATE BOARD OF**
LICENSE NO.: 17530	*	**PHYSICAL THERAPY EXAMINERS**
Respondent	*	**CASE NUMBER: PT 11-43**

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CONSENT ORDER

On or about December 26, 2012, the State Board of Physical Therapy Examiners (the "Board") charged **TANYA HEGE-MAISEL, P.T.** (the "Respondent") **LICENSE No. 17530,** with violations of the Maryland Physical Therapy Act (the "Act") codified at Md. Health Occ. Code Ann. § 13-101, *et seq.*, (2009 Repl. Vol. and 2012 Supp.).

Specifically, the Board charged the Respondent with violating the following provisions of H.O. § 13-316:

> **13-316. Denials, reprimands, probations, suspensions and revocations-Grounds**
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> 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:
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> (4) In the case of an individual who is authorized to practice physical therapy is grossly negligent:
>
> (i) In the direction of an individual who is authorized to practice limited physical therapy;
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> (11) Practices physical therapy or limited physical therapy with an unauthorized person or supervises or aids an unauthorized person in the practice of physical therapy or limited physical therapy;
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> (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[.]

The pertinent provisions of the Code of Maryland Regulations ("COMAR") referred to, *infra,* in §13-316(15) provides the following:

COMAR 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.

COMAR 10.38.03.02 Standards of Practice.

A. (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; and

(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 therapy assistant only treatment that is within the competency and scope of practice of the physical therapy assistant;

(k) Provide direction and instruction for the physical therapy 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 patient 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 that 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 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.

(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:

(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; and

(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.

On or about February 19, 2013, the Respondent appeared before the Case Resolution Conference Committee (the "CRC") of the Board in order to attempt to resolve the Charges against her. The Respondent agreed to enter into this Consent Order as a full and final resolution of the Charges.

FINDINGS OF FACT

The Board finds the following:

1. The Respondent was initially licensed to practice physical therapy ("P.T.") in the State of Maryland on or about August 25, 1993. Her license will expire on May 31, 2014.

2. At all relevant times, the Respondent was employed as a licensed physical therapist by a private health care practice ("Facility A")[1].

3. On or about April 11, 2011, the Board received an anonymous complaint alleging that the Respondent had knowledge that her employer, the owner of Facility A ("Owner A") was practicing physical therapy without a license. The complaint further

[1] To protect their privacy, the names of facilities and persons involved in this matter have been withheld in this document but are known to the Respondent.

alleged that the Respondent knew or should have known that Owner A was using Respondent's license number in order to falsely justify payment for services rendered.

4. Thereafter, the Board initiated an investigation during which the identity of the anonymous complainant ("the complainant") was discovered.

5. The results of the Board's investigation are set forth, *infra.*

I. BOARD INVESTIGATION

6. On or about April 28, 2011, Board staff interviewed the complainant, a former patient of Facility A, who stated that she was treated approximately 89 times during a 2 ½ year period of time from June 6, 2008 to September 10, 2010. In response to a subpoena, the complainant also provided the Board with copies of treatment and billing records.

7. The Board's investigation revealed that the Respondent performed an initial evaluation and saw the complainant on only one (1) other occasion. Following the Respondent's initial evaluation, Owner A, an unlicensed individual, treated the complainant for cervicalgia and postural dysfunction. The billing records indicated that the complainant received various modalities of P.T., including therapeutic exercise, manual therapy, neuromuscular re-education and massage or joint mobilization.

8. Although twenty-three (23) re-evaluations were required during the course of treatment, Respondent failed to re-evaluate the complainant at any time.

9. The complainant estimated that she and/or her insurer[2] paid Facility A in excess of $9,000 for P.T. treatment. The Board's investigation revealed that the Respondent's name and license number was used on bills and insurance claim forms.

[2] Although unclear from the patient charts, it appears that patients paid fees for services directly to Facility A and would later submit bills to their insurance companies. The bills referenced CPT codes reserved for P.T. treatment only.

10. The complainant further stated that several family members were also treated by Facility A and were consistently charged $90.00 per visit for therapeutic exercises, neuromuscular re-education, manual therapy and mobilization. It was alleged that this treatment was routinely provided by Owner A, but billed under the name and license number of the Respondent or a physical therapy assistant, ("Assistant A").

11. In furtherance of its investigation, the Board subpoenaed twenty-five (25) patient records[3] and other relevant documents. The Board also conducted interviews of three (3) other patients, who corroborated information alleged in the complaint.

Patient A

12. Patient A, a 51 year-old female, was treated at Facility A from October 26, 2010 through March 2011. The Respondent performed an initial evaluation, concluding that the patient suffered from cervicalgia and neurofibroma with left side facial nerve paralysis. Although Respondent was required to perform re-evaluations every thirty (30) days, on or about December 26, 2010, January 26, 2010, or February 26, 2010, respectively, none were performed.

13. Patient A was treated at Facility A on twenty-two (22) occasions, but was seen by the Respondent on only four (4) visits. At each of those visits, the Respondent was required to review Patient A's medical chart, discuss progress and modify treatment based on the patient's medical status.

14. Owner A submitted bills for therapeutic exercise, neuromuscular stimulation and mobilization to Patient A using the Respondent's license number. Based on weekly office meetings between Owner A, Assistant A, and the Respondent, the

[3] Owner A and Assistant A, as the resident agent of Facility A, failed to produce all of the subpoenaed records claiming that they had misplaced several patient files.

Respondent knew that Owner A was not documenting his treatment in the medical record.

Patient B

15. Patient B, a 49 year-old male, was a patient of Facility A for approximately five (5) years from 2006-2011. His most recent treatment, beginning on December 29, 2010, focused on back and hip pain resulting from an injury.

16. Between January 6, 2011 and March 23, 2011, the Respondent treated Patient B twice. Owner A and/or Assistant A treated Patient B on eleven (11) additional occasions, all of which were billed under the Respondent's name and license number.

17. The Respondent was required to perform re-evaluations every thirty (30) days on or about January 29, 2011, February 29, 2011 or March 25, 2011, respectively. None of the required re-evaluations were performed.

18. The Respondent was also required to routinely review Patient B's medical chart, discuss progress and modify treatment based on the patient's medical status. She should have suspected that Owner A was providing ongoing treatment to Patient B and billing for therapeutic exercise, neuromuscular stimulation and mobilization. Respondent was aware that Owner A was not documenting his treatment in the medical record.

Patient C

19. Patient C, a 27 year-old female, was a patient of Facility A for approximately four (4) years from June 24, 2007- April 6, 2011, following a diagnosis of Lyme disease. Her most recent treatment regimen began on February 12, 2010 when she presented with back pain, fatigue and limited tolerance to standing or sitting. She

was initially treated by the Respondent and was subsequently treated by both Owner A and Assistant A.

20. Although Patient C was treated on approximately forty-nine (49) occasions, only four (4) visits were adequately documented. The Board's investigation revealed that for the vast majority of visits, the billing record was the sole source of information documenting that a visit had taken place. All visits were billed under the Respondent's name and license number, but Owner A provided treatment on many of the 49 visits.

21. The Respondent was required to review Patient C's medical chart, discuss progress and modify treatment based on the patient's medical status. She should have suspected that Owner A was billing Patient C for treatment that he provided including therapeutic exercise, neuromuscular stimulation and mobilization. The Respondent was aware that Owner A was not documenting his treatment in the medical record.

Assistant A

22. On or about March 6, 2012, Board staff interviewed Assistant A. She stated that she and the Owner A opened Facility A in 2006 as co-owners[4]. In 2007, she sold her equity interest in the business to Owner A. From the inception of the partnership, she and Owner A were involved in an intimate relationship. The Respondent was aware of this personal relationship.

23. Assistant A stated that Owner A did not hold a P.T. license in Maryland and that his expertise was limited to *Reiki*, a form of energy work similar to manual therapy.

[4] By letter dated March 22, 2012, counsel for Assistant A submitted a supplement to Assistant A's sworn interview. The letter clarified that Facility A was established as a Limited Liability Corporation on August 29, 2005 and that Assistant A maintained an equity interest in the LLC from January 1, 2006-December 31, 2006. At all times relevant, Assistant A was listed as the resident agent for the LLC.

24. Assistant A admitted that initial evaluations and re-evaluations were not performed in a timely manner and sometimes not at all. She conceded that without a proper and timely re-evaluation, P.T. should have been placed on hold and/or terminated. Assistant A stated that she told the Respondent that thirty (30) day re-evaluations were not being performed as required.

25. Assistant A conceded that her documentation was inadequate and that her notes were not maintained in a consistent and timely manner. The Respondent was aware of Assistant A's documentation deficiencies but did not routinely counsel her or audit her records.

26. Neither Assistant A nor the Respondent properly and consistently documented their alleged weekly communication(s) regarding patients. They also failed to document any conversations with Owner A regarding the care that he provided to Facility A's patients.

27. Assistant A stated that she delegated her billing to an office manager. She admitted that all bills were essentially for the same amount and billed under the same CPT codes irrespective of the patients' presenting symptoms, subsequent progress, respective health care provider or treatment modalities utilized. At some point, the Respondent's name and license number was used on all patient bills, even for services provided by Assistant A and/or Owner A.

The Respondent

28. On or about March 7, 2012, Board staff interviewed the Respondent. She stated that she had been employed with Facility A from 2006-2011. As part of her responsibilities, the Respondent agreed to provide professional oversight and supervision to Assistant A.

29. During the course of her employment, the Respondent believed that Owner A held a valid license to practice massage therapy in the State of Maryland. At no time did she believe that Owner A held a valid license to practice P.T.

30. The Respondent admitted that since leaving her employment with Owner A, she realized that "maybe some things were not quite the way they should have been, run the right way...." She further stated that during the course of her employment, she knew that Assistant A failed to adequately or timely document treatment provided to shared patients and that Owner A maintained no documentation of his treatment. She did not attempt to address these issues with Owner A or Assistant A, or report these violations of the Act to the Board.

31. The Respondent stated that Owner A provided cranial sacral therapy to patients, a form of manual therapy performed by physical therapists and massage therapists. At times, the Respondent co-treated patients with Owner A. She was aware that insurers typically did not reimburse massage therapists for manual therapy but would reimburse a physical therapist for similar treatment.

32. The Respondent did not review the invoices submitted to patients.

33. The Respondent stated that Facility A charged each patient the same amount for each treatment session. During her interview when shown copies of patient invoices, the Respondent acknowledged that bills were duplicates of one another and reflected identical modalities of treatment, irrespective of the presenting symptoms or injury.

34. The Respondent admitted that she did not perform re-evaluations every thirty (30) days as required and that she was aware that both Owner A and Assistant treated patients without the benefit of re-evaluations.

35. The Respondent failed to provide consistent supervision to Assistant A. The Respondent denies knowledge of Assistant A exceeding the scope of her duties as a physical therapy assistant.

Board Expert

36. On or about April 25, 2012, the Board retained an expert consultant ("Board expert") to review relevant patient and billing records as well as interview transcripts. In addition to reviewing the records and transcripts of Patients A-C, the Board expert also reviewed sixteen (16) patient records produced by Owner A/Facility A responsive to the Board's subpoena(s).

37. The Board expert issued a report on or about May 21, 2012. In that report, the Board expert summarized the Respondent's care and treatment of each patient and further provided expert opinions, to a reasonable degree of medical probability, as to numerous deficiencies in that care.

38. Based on the Board expert's opinions, the Board found that the Respondent practiced P.T. with an unauthorized person, that she failed to report Owner A's unlicensed practice to the Board, that she acted unprofessionally, and violated the applicable Code of Ethics. The Respondent further failed to routinely perform initial evaluations, re-evaluations and/or develop treatment plans in a timely manner. She further failed to legibly document initial evaluations, re-evaluations, communications between providers, and/or discharge summaries.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated H.O. § 13-316 (11) Practices physical therapy or limited

physical therapy with an unauthorized person or supervises or aids an unauthorized person in the practice of physical therapy or limited physical therapy; (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. The Respondent's actions further constitute violations of COMAR 10.38.02.01F, 10.38.03.02A (2) (a),(e),(g),(k) and (l) Standards of Practice and 10.38.03.02-1A (1)(a-j), (3)(c-i) and (4)(a-e) Requirements for Documentation. The Board dismisses the Charges under H.O. § 13-316 (4) In the case of an individual who is authorized to practice physical therapy is grossly negligent: (i) In the direction of an individual who is authorized to practice limited 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; and (20) Grossly overutilizes health care services[.].

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 19th day of March 2013, by a majority of a quorum of the Board considering this case:

ORDERED that the Respondent's license to practice physical therapy shall be **REPRIMANDED;** and it is further

ORDERED that the Respondent's license to practice physical therapy shall be placed on probation for a period of **TWO (1) YEARS,** to commence from the date that this Consent Order is executed, subject to the following conditions:

1. Within six (6) months of the date of the Consent Order, the Respondent shall enroll in and successfully complete a Board-approved course in documentation.

2. Within six (6) months of the date of this Consent Order, the Respondent shall take a closed book Maryland Jurisprudence Examination and achieve a pass rate of 85 % or higher.

3. The Respondent shall provide to the Board documentation of satisfactory completion of all probationary conditions and terms.

ORDERED that the Continuing Education requirements required by this Consent Order shall not count toward fulfilling other continuing education requirements that the Respondent must fulfill in order to renew her license to practice physical therapy; and be it further

ORDERED that the Respondent shall practice according to the Maryland Physical Therapy Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of physical therapy; and be it further

ORDERED that at the conclusion of the **TWO (2) YEAR probationary period**, the Respondent may file a written petition for termination of probationary status without further conditions or restrictions. The Board, in its discretion, may consider whether there are outstanding complaints, investigations or Charges pending against the Respondent.

ORDERED that should the Respondent violate any terms or conditions of this Consent Order, the Board, after notice, opportunity for a hearing and determination of violation, may impose any other disciplinary sanctions it deems appropriate, including reprimand, probation, suspension, revocation or a monetary fine, said violation being proven by a preponderance of the evidence, and be it further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. § 10-611 et seq. (2009 Repl. Vol. and 2011 Supp.).

ORDERED that, for purposes of public disclosure, as permitted by Md. State Gov't. Code Ann. §10-617(h) (Repl. Vol. 2009 and 2011 Supp.), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order, and that the Board may also disclose same to any national reporting data bank that it is mandated to report to.

03/19/13
Date

John Baker, P.T., D.S.C.P.T.
Chair, Board of Physical Therapy Examiners

CONSENT OF TANYA HEGE-MAISEL, P.T.

I, Tanya Hege-Maisel, P.T., acknowledge that I have had the opportunity to consult with counsel before signing this document. By this Consent, I agree and accept to be bound by the foregoing 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, 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 jurisdiction of the Board to initiate these proceedings and to issue

and enforce the 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 an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order. I voluntarily sign this Order, and understand its meaning and effect.

03/14/13
Date

Tanya Hege Maisel, P.T.
Tanya Hege-Maisel, P.T.
Respondent

Read and approved by:

Donna Senft
Donna Senft, Esq., Attorney for the Respondent

NOTARY

STATE OF MARYLAND

CITY/~~COUNTY~~ OF Baltimore :

I HEREBY CERTIFY that on this 14th day of March, 2013, before me, a Notary Public of the foregoing State personally appeared Tanya Hege-Maisel P.T. License Number PT17970, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Dwight Jump
Notary Public

My Commission Expires: 12/5/2013