IN THE MATTER OF

RICHARD B. MAHNKE, P.T.

License No. 21378

Respondent

- BEFORE THE
- * MARYLAND STATE
- * BOARD OF PHYSICAL THERAPY
- * EXAMINERS
- * Case No.: PT-07-09

FINAL CONSENT ORDER

Based on information received and a subsequent investigation by the State
Board of Physical Therapy Examiners (the "Board"), and subject to Md. Health Occ.
Ann. § 13-101, et seq., (2005 Repl. Vol. and 2008 Supp.) (the "Act"), the Board charged
Richard Mahnke, P.T., (the "Respondent"), with violations of the Act. Specifically, the
Board charged the Respondent with violation of the following provisions of § of § 13316 of the Act:

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:

- (4) In the case of an individual who is authorized to practice physical therapy is grossly negligent;
 - (i) In the practice of physical therapy; or
 - 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;
- (13) Willfully fails to file or record any report as required by law, willfully impedes or obstructs the filing or recording of the report,

or induces another to fail to file or record the report;

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

The Board charged the Respondent with violating the following regulations:

Code Md. Regs. ("COMAR") tit. 10 § 38.03. "Standards of Practice" (March 18, 2002):

.02

- 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 re-evaluating the patient;
 - (I) Document ongoing communication with the physical therapist assistant regarding changes in a patient's status and treatment plan[.]

The Board also charged the Respondent with violating the following regulations:

Code Md. Regs. ("COMAR") tit. 10 § 38.03.02-1, "Requirements for Documentation" (March 18, 2002):

A. The physical therapist shall document legibly the patient's chart <u>each</u> time the patient is seen for (emphasis added):

- (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
- 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.

The Respondent was given notice of the issues underlying the Board's charges by letter dated April 7, 2009. Accordingly, a Case Resolution Conference was held on May 21, 2009, and was attended by John Baker, P.T., Board member, Ann Tyminski, Executive Director of the Board, and Linda Bethman and Francesca Gibbs, Counsel to the Board. Also in attendance were the Respondent, who knowingly and voluntarily waived his right to an attorney, and the Administrative Prosecutor, Roberta Gill.

Following the Case Resolution Conference, the parties and the Board agreed to resolve the matter by way of settlement. The parties and the Board agreed to the following:

FINDINGS OF FACT

- At all times relevant to the charges herein, the Respondent was licensed to
 practice physical therapy in the State of Maryland. The Respondent was
 originally licensed on January 24, 2005. The Respondent's license expires on
 May 31, 2010.
- 2. At all times relevant to the charges herein, the Respondent was practicing physical therapy at the Water's Edge, a privately-owned physical therapy practice located in Stevensville, Maryland. The Respondent was employed as the Rehabilitation Director at the Water's Edge from January 16, 2006, until August 18, 2006. The Water's Edge was owned and operated by Owner A, who is not

- licensed by any health occupation licensing board.1
- On or about September 28, 2006, the Board received a complaint from Physical Therapist A, a staff physical therapist previously employed at the Water's Edge. Physical Therapist A alleged in her complaint that the Water's Edge was billing her services to insurance companies and Medicare under the Respondent's name after the Respondent had terminated his employment, effective August 18, 2006.
- 4. As a result of the complaint received from Physical Therapist A, the Board opened an investigation into the allegations in the complaint.
- 5. As part of its investigation, the Board's investigator interviewed Physical Therapist A, who was duly sworn, on October 18, 2006. Physical Therapist A informed the Board's investigator, as follows:
 - A. She began working at the Water's Edge on June 5, 2006;
 - B. According to Physical Therapist A, she discovered that the Water's Edge was billing insurance companies and Medicare under the Respondent's name after the Respondent had terminated his employment;
 - C. Physical Therapist A informed the Board's investigator that, when she became aware of this billing issue, she reported the problem to Physical Therapist B, the successor Rehabilitation Director who took over for the Respondent at the Water's Edge;
 - D. Physical Therapist A told the Board's investigator that she resigned her employment at the Water's Edge, effective September 29, 2006, after discovering

¹ The identities of those listed by a letter are known to the Respondent.

that the practice was continuing to bill her services under the Respondent's name after he had terminated his employment and after she had informed Physical Therapist B of that fact;

- E. Physical Therapist A indicated that the Respondent was behind in writing patient treatment notes, and that she noticed missing patient treatment notes in patients' records, including missing initial evaluations;
- F. According to Physical Therapist A, the Respondent admitted to her that he was behind in writing patient treatment notes.
- 6. As a result of the interview with Physical Therapist A, the Board's investigator issued a subpoena duces tecum, dated October 23, 2006, directed to the Water's Edge for patient treatment and billing records to verify the allegations rendered by Physical Therapist A.
- On or about November, 2006, the Board received copies of patient treatment and billing records from the Water's Edge, pursuant to its October 23, 2006, subpoena. Upon inspection, the Health Insurance Claim Forms (HICF) revealed that services were billed under Physical Therapist B, not the Respondent, as alleged by Physical Therapist A.
- 8. As a result of the discrepancy between the records and her complaint, the Board's investigator again met with Physical Therapist A on or about December 7, 2006. Physical Therapist A inspected the records obtained by the Board and informed the Board's investigator that the billing records had been manufactured. According to Physical Therapist A, the original billing records were billed under the Respondent's

name.

- The Board's investigator interviewed Owner A, who was duly sworn, on January 3,
 2007:
 - A. Owner A informed the Board's investigator that she became concerned about the Respondent's billing and record keeping practices about one month after first hiring the Respondent in January 2006;
 - B. According to Owner A, in or about March 2006, she discovered a stack of billing forms on the Respondent's desk;
 - C. Owner A further testified that she discovered a file cabinet full of files whereby the Respondent was keeping handwritten notes on patients, sometimes writing an initial evaluation on a "yellow legal sheet of paper;"
 - D. Owner A provided the Board's investigator with written reports from the Respondent's personnel record at the Water's Edge detailing numerous times where the Respondent failed to properly document initial evaluations, reevaluations, and patient treatment notes;
 - E. Owner A admitted to the Board's investigator that the Water's Edge did go back to change the name of the physical therapist providing the documented services contained in the HICF submitted to the Board after receiving the Board's subpoena. Owner A admitted that the original documents reflected the Respondent as the service provider, thereby verifying the allegation made by Physical Therapist A in her complaint to the Board.
- 10. As part of its investigation, the Board's investigator interviewed Officer Manager A,

who was duly sworn, on May 29, 2007:

- A. Officer Manager A informed the Board's investigator that she assisted

 Owner A in assessing patient records at the Water's Edge to determine compliance

 with documentation standards;
- B. Office Manager A testified that she discovered numerous problems with the record-keeping and documentation practices of the Respondent while employed at the Water's Edge;
- C. According to Office Manager A, the Respondent would see approximately twelve (12) to thirteen (13) patients per day at the Water's Edge, but the practice would receive only two patient treatment notes;
- D. Officer Manager A indicated that the Respondent would always fill out the billing forms, but patient treatment notes would not be completed. Accordingly, Office Manager A stated that she would be in possession of a bill submitted by the Respondent for an initial evaluation, but no written initial evaluation would be present in the patient's record;
- E. Office Manager A estimated that the Respondent failed to submit five-hundred (500) patient treatment notes while employed at the Water's Edge.
- 11. The Respondent was interviewed by the Board's investigator and testified under oath, as follows:
 - A. The Respondent stated that he filled out a "super bill" each time he treated patients at the Water's Edge and submitted it to the billing office;

- B. He further testified that he fell behind in completing his evaluations. According to the Respondent, he would take handwritten notes of his evaluations and reevaluations and enter them into the computer system at the Water's Edge at a later time. The Respondent admitted that there was a delay between the time that he took handwritten notes of his evaluations and reevaluations and put them into the digital system at the Water's Edge.
- C. The Respondent admitted to the Board's investigator that he did not complete evaluations and reevaluations prior to Physical Therapist Assistant A treating his patients at the Water's Edge. The Respondent further admitted that it would be difficult for a physical therapist assistant to render treatment to these patients at the Water's Edge without a formal evaluation or reevaluation from him;
- D. After leaving his employment at the Water's Edge, the Respondent admitted that he manufactured patient initial evaluations, reevaluations, and treatment notes for patients that he treated during his employment at the Water's Edge by going to the facility after hours and on weekends. The Respondent further admitted to the Board's investigator that he faxed manufactured patient treatment notes to the Water's Edge as late as November 2006, approximately four months after leaving his employment there;
- 12. The physical therapy treatment records of fifteen patients from the Water's Edge treated by the Respondent were referred to an expert witness in physical therapy, who concluded that the Respondent violated the Act and regulations in several

ways, as follows:

- A. The Board's expert concluded, among other opinions, that thirteen of the fifteen patient treatment records contained no initial evaluation by the primary physical therapist--the Respondent. Despite this, the initial evaluations were billed and reimbursed by the insurance companies and Medicare;
- B. Many of the notes provided by the Respondent were for patients seen much earlier than the notes reflected;
- C. The expert concluded that the Respondent violated the Act by failing to timely document an initial evaluation in the patients' charts, in that the initial evaluation establishes the medical necessity for continued care, and, without it, the physical therapy intervention is not legal and the subsequent intervention is not reimbursable:
- D. The expert further concluded that, without the signature of the therapist rendering the care, as well as the professional designation of the P.T. and license number, the care cannot be reimbursed;
- E. Further, according to the expert, there must be documentation for every treatment day and every therapy service. Without same, the treatments are not reimbursable;
- F. Furthermore, the expert concluded that there must be documentation that shows that there is ongoing communication between the P.T. (the Respondent) and the P.T.A.

- 13. The Respondent acknowledged that he did have cryptic handwritten evaluations, daily notes and reevaluations after seeing each patient on a daily basis that were kept in a file and that, although there is no documentation to that effect, he and Physical Therapist Assistant A communicated often about the patients, and she could read his notes or would ask him for clarifications.
- 14. As set forth above, the Respondent violated the Act and regulations thereunder.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board finds that Respondent violated §13-316 (4) (i) (ii), (12), (13), (15), (19), (25) of the Act, Code of Md. Regs. Title 10 §38.03.02 A (2) (a), (e), (g), (l), Title 10 § 38.03.02-1 A (1) (a-j), (2) (a-g), (3) (a-i), (4) (a-d), D and E.

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 2/26 day of _______, 2009, by a majority of a quorum of the Board, ORDERED that the Respondent is hereby REPRIMANDED; and, be it further ORDERED that the Respondent be placed on PROBATION for at least two years,

subject to the following:

A. During the first year of Probation, the Respondent shall successfully complete the Board's law and ethics course;

- B. During the first year of Probation, the Respondent shall also successfully complete a Board-approved documentation course;
- C. The Respondent shall bear the costs of complying with the Board's
 Order;

ORDERED that the Consent Order is effective as of the date of its signing by the Board; and be it

ORDERED that, should the Board receive a report that the Respondent has violated the Act or if the Respondent violates any conditions of this Order or of Probation, after providing the Respondent with notice and an opportunity for a hearing, the Board may take further disciplinary action against the Respondent, including suspension or revocation. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order or of Probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and be it

ORDERED that the Respondent shall practice in accordance with the laws and regulations governing the practice of physical therapy in Maryland; and be it further

ORDERED that, at the end of the Probationary period, the Respondent may petition the Board to practice without any conditions or restrictions on his license, provided that he can demonstrate compliance with the conditions of this Order. Should the Respondent fail to demonstrate compliance, the Board may impose additional terms and conditions of Probation, as it deems necessary;

ORDERED that, for purposes of public disclosure, as permitted by Md. State Gov't.

Code Ann. §10-617(h) (Repl. Vol. 2004), 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.

Margery Rodgers P.T., Chair

State Board of Physical Therapy Examiners

CONSENT OF RICHARD MAHNKE

I, by affixing my signature hereto, acknowledge that:

- I am not represented by an attorney and have knowingly waived my right to same;
- 2. I am aware that, without my consent, my license to practice physical therapy _in this State cannot be limited except pursuant to the provisions of § 13-316 of the Act and the Administrative Procedure Act (APA) Md. State Govt. Code Ann. §10-201, et seq., (2004 Repl. Vol.).
- 3. I am aware that I am entitled to a formal evidentiary hearing before the Board By this Consent Order, I hereby consent and admit to the foregoing Findings of Fact, Conclusions of Law and Order, provided the Board adopts the foregoing Consent Order in its entirety. By doing so, I waive my right to a formal hearing as set forth in §13-317 of the Act and §10-201, et seq., of the APA, and any right to appeal as set forth in § 13-318 of the

Act and §10-201, et seq., of the APA. I acknowledge that my failure to abide by the conditions set forth in this Order and following proper procedures, I may suffer disciplinary action, possibly including revocation, against my license to practice physical therapy in the State of Maryland.

Date

OG/30/2009

Date

Ogl/30/2009

Richard Mahnke, P.T.

STATE OF Maryland:
CITY/COUNTY OF Battimore City

personally appeared Richard Mahnke, License No. 21378, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notarial seal.

Notary Public

My Commission Expires: 01-01-2011

Baltimore City, MD My Commission Expires: