IN THE MATTER OF	*	**BEFORE THE MARYLAND**
TAMMY W. MARK, P.T.	*	**STATE BOARD OF PHYSICAL THERAPY**
	*	**EXAMINERS**
LICENSE NO.: 21020		
Respondent	*	**CASE NUMBER: PT12-32**

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

CONSENT ORDER

On or about April 10, 2013, the Maryland Board of Physical Therapy Examiners (the "Board") charged **TAMMY W. MARK, P.T.,** ("the Respondent"**) LICENSE NO. 21020**, with violations of the Maryland Physical Therapy Act (the "Act") codified at Md. Health Occ. Code Ann. ("H.O.") § 13-101, *et seq.*, ("the Act") (2009 Repl. Vol. and 2012 Supp.).

Specifically, the Board charged the Respondent with violating:

H.O. §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, 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 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;

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

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;

(b) Provide:
(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;

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

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

On or about May 14, 2013, the Respondent appeared before a Case Resolution Conference Committee of the Board in order to explore a potential resolution of the matter. 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 on or about September 23, 2003 under license number 21020. Her license will expire on May 31, 2014.

2. At all relevant times, the Respondent was employed as a physical therapist with a home health care agency ("Employer A"). On or about June 4, 2012, the Respondent resigned from her employment with Employer A.

3. On or about June 25, 2011, the Board received a complaint from Employer A alleging that the Respondent had falsified patient records.

4. Thereafter, the Board initiated an investigation.

5. It was reported to the Board that during the course of an internal investigation, Employer A discovered that the Respondent had falsified treatment notes, billed for treatment not rendered, "cut and pasted" notes from one treatment session to another, and had prematurely discharged a patient from care despite the patient's need for continued treatment.

6. On or about August 28, 2012, the Board conducted an interview of the rehabilitation director of Employer A ("Director A") who stated that a female patient ("Patient A") reported that the Respondent had missed a therapy appointment scheduled for April 25, 2012. According to Patient A, the Respondent did not call to cancel or reschedule the appointment.

7. In response to Patient A's complaint, Director A reviewed Patient A's treatment records and discovered that the Respondent had documented and billed for a functional and pain evaluation performed on April 25, 2012. The Respondent's notes and billing were inconsistent with Patient A's statement that a treatment session did not occur.

Other health care providers who evaluated Patient A on that same day, documented findings that were determined by Employer A to be inconsistent with certain aspects of the Respondent's notes.

8. Director A conducted an internal chart audit that included a review of a random sample of the Respondent's charts, and interviews of seven (7) patients treated by the Respondent. The internal chart audit revealed discrepancies between treatment and billing records.

9. On or about August 29, 2012, the Board interviewed the Respondent. The Respondent emphatically stated that she treated Patient A on April 25, 2012 from 1:21-2:30 p.m. Contrary to Employer A's stated policy requiring patient signatures at the conclusion of a therapy session, the Respondent stated that her treatment notes for that day were signed by a nurse with a time stamp of 1:39 p.m., fifty-one (51) minutes before the treatment session allegedly ended. The Respondent understood Employer A's policy to allow a caregiver to sign. The nurse that signed the form was Patient A's caregiver on that day. The Respondent was further questioned regarding her pain assessment rating for Patient A. She documented that Patient A's pain was a 4/10 at the time of her evaluation. Three (3) hours earlier, an occupational therapist assessed Patient A's pain as a 9/10, rendering her unable to comfortably participate in therapy. Patient A's medical record reflected that Patient A had received dilaudid for pain management following the treatment by the occupational therapist, and that the dilaudid provided effective pain relief for Patient A. The Respondent reiterated that she treated Patient A on April 25, 2012.

10. The Respondent was also questioned regarding:

a) prematurely discharging a female patient ("Patient B") despite other health care providers' assessments that Patient B was suffering from serious balance issues requiring continued treatment;

b) cutting and pasting notes and findings from one treatment session to another;

c) arriving for an unscheduled appointment with an elderly male patient ("Patient C") at the same time that another health care provider was providing care; and

d) documenting that on May 11, 2012, the Respondent performed a one (1) hour evaluation of Patient C at the same time that another health care provider was providing care in a different modality.

11. The Respondent stated that Patient B was evaluated prior to discharge and was not suffering from balance issues requiring continued home health care; and that in her opinion, discharge was required because Patient B was no longer homebound. The Respondent further stated that she verbally advised the assigned physical therapy assistant of her intention to discharge Patient B. The Respondent admitted that she failed to document verbal communication with the assigned physical therapy assistant regarding changes in treatment status, goals and discharge of Patient B.

12. The Respondent admitted that she used a charting "template" whereby she "cut and paste" documentation of treatment plans from prior sessions. She was aware that a physical therapy assistant, under her supervision, was also using a similar template. The Respondent conceded that by using this template, she mistakenly documented "prosthetic training" in the plan of care for a patient who did not have a prosthesis. This treatment plan component had been cut and pasted from another patient's chart. During an internal audit on or about February 24, 2012, Employer A advised the Respondent of this issue. Subsequent to the audit, Respondent confirmed that she no longer used the template.

13. The Respondent denied that she had failed to schedule an appointment with Patient C, stating that Patient C's caretaker had scheduled the appointment for May 11, 2012. The Respondent stated that she co-treated Patient C during the same time period that he was being treated by another health care provider. The Respondent was confronted with discrepancies between her documentation and testimony, and that of other witnesses interviewed by the Board. The Respondent provided explanations for some of the discrepancies but was unable to reconcile others, stating that she could was unable to explain the inconsistencies between her testimony and that of other witnesses.

14. On or about June 4, 2012, after being advised of the billing, treatment and documentation discrepancies, the Respondent resigned from her employment with Employer A.

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 (12) Willfully makes or files a false report or record 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; and (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy.

The Board further concludes that the Respondent violated the regulatory Standard of Practice requirements set forth in COMAR 10.38.03.02A(2)(b)(ii),(c).

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; (14) Submits a false statement to collect a fee; and further dismisses the Charges under COMAR 10.38.03.02 (a) Exercise sound professional judgment in the use of evaluation and treatment procedures; (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[.]

The Board found certain mitigating factors under COMAR 10.38.10.05C were present in this case, including (1) [t]he licenses's lack of a prior disciplinary record and (6) [e]vidence of rehabilitation or rehabilitative potential. The Board further relied on evidence in the investigation record that reflected: (a) several performance reviews identifying above-average performance, and (b) interviews of patients with good cognition, all of whom reported receiving good care and substantiated Respondent's documentation.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 11th day of July 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 **SUSPENDED** for a period of **SIX (6) MONTHS, FIVE (5) MONTHS STAYED, THIRTY (30) DAYS ACTIVE SUSPENSION,** to be served in its entirety within **four (4) months** of the execution of this Consent Order; and it is further

ORDERED that the Respondent's license to practice physical therapy shall be placed on probation for a period of **TWO (2) YEARS,** to commence from the date that this Consent Order is executed, subject to the following conditions:

1. Within 120 days of the date of the Consent Order, the Respondent shall make payment to the Board, by certified check or money order, a **MONETARY FINE** in the amount of two thousand five hundred dollars **($2,500).**

2. 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.**

3. Within six (6) months of the date of this Consent Order, the Respondent shall enroll in and successfully complete a Board-approved course in **billing and coding.**

4. Within six (6) months of the date of this Consent Order, the Respondent shall take a closed book **Maryland Jurisprudence Examination** at the Board's offices and achieve a pass rate of 80 % or higher.

5. The Respondent shall provide to the Board documentation of satisfactory completion of all probationary conditions and terms, including but not limited to the continuing education requirements set forth above.

6. The Respondent shall practice in a supervised practice setting during the entirety of the probationary period and shall ensure that her clinical supervisor submits to the Board quarterly status reports evaluating her compliance with the Act including but not limited to billing, documentation, ethical requirements and standards of practice.

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 2012 Supp.).

07/11/13
Date

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

CONSENT OF TAMMY MARK, P.T.

I, Tammy Mark 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.

7/3/13
Date

Tammy Mark, P.T.
Respondent

Read and approved by:

Donna Senft, Esq.,
Attorney for the Respondent

NOTARY

STATE OF MARYLAND

CITY/~~COUNTY~~ OF Baltimore **:**

I HEREBY CERTIFY that on this 3rd day of July, 2013, before me, a Notary Public of the foregoing State personally appeared Tammy Mark

P.T. License Number PT 21020 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.

Delight Jump
Notary Public

My Commission Expires: 12/5/13

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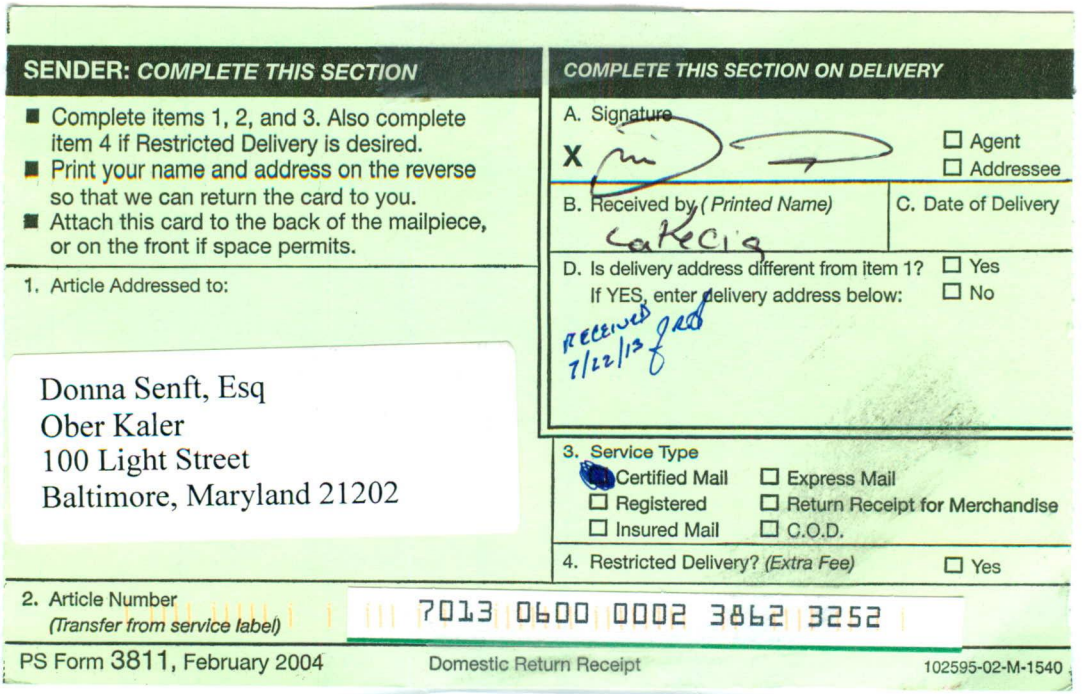

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