IN THE MATTER OF	*	**BEFORE THE STATE BOARD**
STEPHEN D. RYAN, P.T.	*	**OF PHYSICIAL THERAPY**
License No.: 15286	*	**EXAMINERS**
Respondent	*	**Case Nos.: PT 13-26 and PT 15-66**

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CONSENT ORDER

On January 28, 2016, the State Board of Physical Therapy Examiners (the "Board") charged Stephen D. Ryan, P.T. (the "Respondent") with violations of certain provisions of the Maryland Physical Therapy Act (the "Act"), Md. Code Ann., Health Occupations ("Health Occ.") §§ 13-101 *et seq*.

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

> 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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> …
>
> (14) Submits a false statement to collect a fee;
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> (15) Violates any provision of this title or rule or regulation adopted by the Board;
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> …
>
> (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy[.]

The Board further charged the Respondent with the following violations of Code of Maryland Regulations (Md. Code. Regs.) 10.38.02.01 B – Code of Ethics:

…

B. The physical therapist…shall respect the dignity of the patient.

…

K. The physical therapist…may not intimidate or influence any person to withhold or change testimony in hearings or proceedings before the Board or those otherwise delegated to the Office of Administrative Hearings.

L. The physical therapist…may not hinder, prevent, or otherwise delay any person from making information available to the Board in furtherance of any investigation by the Board.

The Board further charged the Respondent with the following violations of Md. Code. Regs. 10.38.02.02 – Sexual Misconduct:

A. A physical therapist…may not engage in sexual misconduct.

B. Sexual misconduct includes, but is not limited to:

…

(2) Sexual behavior with a client or patient under the pretext of diagnostic or therapeutic intent or benefit[.]

On March 15, 2016, a conference with regard to this matter was held before the Board's Case Resolution Committee ("CRC"). As a result of the CRC, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. 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 June 16, 1982. He renewed his license on April 21, 2014 and his license expires on May 31, 2016.

2. At all times relevant to the charges herein, the Respondent owned, operated and practiced as a physical therapist at Practice A, located in Hagerstown, Maryland.[1]

3. While working at his practice, the Respondent also employed and supervised physical therapy assistants, an office manager and other support staff.

I. CASE NUMBER PT 13-26

Procedural History

4. On or about February 12, 2013, the Board received a written complaint from an individual ("the Complainant") who reported that she had been employed at Practice A by the Respondent and that she had knowledge that the Respondent routinely altered charge tickets and charged for additional services that were never rendered.

5. In furtherance of its investigation regarding this complaint, Board staff interviewed two employees of Practice A, including the Complainant, and one physical therapy assistant ("PTA") then employed by the Respondent. The Board subpoenaed patient records which were reviewed by a PT retained by the Board for this purpose. The Board's investigatory findings relevant to the Respondent are set forth below.

[1] The names of patients, facilities and other individuals are confidential.

General Findings of Fact Relevant to the Respondent

6. The Board's investigation revealed that the Respondent filed false claims by altering the PTA's "superbill" (a charge ticket used by clinicians in the office to indicate services provided to individual patients) to increase billing.

7. The Board investigation further revealed that the Respondent or PTA prepared a superbill after treating a patient, checking off the CPT codes[2] for the treatments they had provided to the patient; when both the Respondent and PTA treated the same patient, both would use the same superbill.

8. The completed fee sheets were placed in a basket for non-licensed clerical employees to use a computer billing program to enter charges. The employees, who were neither PTs nor PTAs, were not present as the Respondent or other PT staff was treating patients and had no personal knowledge of the treatment provided.

9. In her written complaint, the Complainant stated that she had worked full-time as office manager for Practice A from sometime in February 2012 until November 1, 2012. The Complainant stated the Respondent fired her on November 1, 2012.

10. When interviewed by Board staff, the Complainant, who had worked in the medical field for 35 years when employed by the Respondent, stated that she had implemented a billing system in which services were entered onto a claim in order of relative value unit ("RVU"). The Complainant stated that

[2] The acronym "CPT" is the abbreviation for Current Procedural Terminology. CPT codes provide a uniform language that accurately describes medical, surgical and diagnostic procedures and is extensively used in the processing of health care claims.

she had revised the superbill so that services were listed sequentially from highest RVU to lowest.

11. The Complainant further stated that the Respondent routinely took home the superbills each evening and returned them the next morning, often with additional charges. The PTA would add the changes indicated by the Respondent before sending in the claim.

12. The Complainant stated that she had confronted the Respondent regarding his practice of changing the PTA's superbills because the Respondent had not taken the patients' charts home when reviewing the superbills and thus was not aware what services were or were not provided to patients.

13. In or around October 2012, the Complainant was alerted by a staff member to a bill on which a "higher valued" code appeared at the bottom of the claim rather than in sequential order. The Complainant traced the transaction to the Respondent. Although she attempted to disable his access to the billing module, the Respondent regained his access and made additional "adjustment entries."

14. Review of patient claims reveals multiple instances in which higher valued services are listed at the bottom of the claim in the absence of documentation to support those charges.

15. During the Complainant's interview with Board staff, she stated that she had brought to the PTA's attention that the Respondent was modifying superbills that the PTA had prepared to add units or add charges. The PTA

acknowledged this could happen, but that once the superbill left his control he could not be responsible for any modification.

16. During the PTA's initial interview, Board staff showed him several fee sheets that he had originally completed that had been changed by the Respondent to add units of existing treatments or add more expensive treatments.

17. During the PTA's second interview with Board staff, he stated once he realized his superbills were being modified after leaving his control, he began copying them and hiding the copied superbills in his desk at Practice A's office.

18. During the PTA's second interview with Board staff, he stated he could not provide copies of any superbills because "somebody had gone through my desk and taken them."

19. During the PTA's second interview with Board staff, he acknowledged some of his superbills must have been changed because final billing (shown to him during the interview) did not reflect the documentation which the PTA confirms he completed in the treatment record.

20. An expert reviewer ("expert") conducted a review of ten Practice A patients (Patients 1 – 10). For each patient, the expert found multiple instances of services being billed in the absence of documentation to indicate that the billed service had been provided.

21. In each of the ten records, the expert found that the Respondent's documentation of his treatment of patients was scant. In addition, the Respondent consistently failed to indicate patient in/out times. When interviewed

by Board staff, the Respondent stated that he "[d]idn't know it was required." The Respondent's deficient documentation and lack of treatment times failed to support the services and/or units of services provided to each patient.

22. When interviewed under oath by Board staff, the Respondent was asked how the services that he and his staff billed corresponded to the treatment notes because many billed services were not documented. The Respondent replied: "Well, you can't. If you're going to do that, then you can't correspond it."

23. In addition to the general deficiencies as stated above, the expert found the following:

a. The Respondent failed to document treatment provided during his evaluation and re-evaluation of patients – Patients 1, 2, 3, 4, 5, 6, 7, 8 and 9. When Board staff asked the Respondent regarding his failure to document treatment when evaluating a patient, the Respondent stated that, "…it's just assumed when a patient comes in for an evaluation you're going to treat them unless you say you're just going to do an evaluation."

b. The Respondent failed to document specific service(s) for which he billed on multiple visits– Patient 3, 7, 8;

c. In several instances, additional services were charged in direct contradiction to the documentation in the patient's chart. For example and not in limitation, on one visit, the PTA noted that Patient 2 refused any activity other than ultrasound and electrical stimulation; however, on that date, therapeutic function was

charged in addition to ultrasound and electrical stimulation. Similarly, on at visit in July 2013, the PTA documented that Patient 4 requested infrared treatment only, yet one unit each of neuromuscular re-education and therapeutic exercise was billed. On two separate visits in July and October 2012, the Respondent documented that Patient 10 was unable to complete his entire treatment routine due to fatigue. The Respondent, however, billed the same number of units on those dates as if Patient 10 had completed his treatment routine.

d. Patient 10 was treated in the Respondent's clinic several times a month by the Respondent or the PTA from October 2010 through November 2014. Comparison of the re-evaluations fails to provide evidence for the necessity of continuation of care for four years.

II. CASE NUMBER PT 15-66

24. On or about June 29, 2015, the Board received information from a PT that a current patient of hers ("Patient 11") had disclosed that the Respondent had inappropriately touched her during a treatment session several years earlier.

25. On or about July 3, 2015, Patient 11 submitted a complaint to the Board in which she detailed the Respondent's inappropriate conduct during a treatment session. Patient 11 also stated that on July 3, 2015, as she was writing her complaint, the Respondent telephoned her and asked whether she had filed a complaint. Patient 11 reported that the Respondent stated he was suffering from Lyme disease at the time his conduct occurred. The Respondent

told Patient 11 that he had been “psychotic” as a result of Lyme disease and had no memories of his conduct.

26. The Board thereafter initiated an investigation of Patient 11’s complaint. In furtherance of its investigation, Board staff interviewed the Respondent, Patient 11 and two individuals to whom Patient 11 had disclosed the Respondent’s conduct. The Board accepted the Respondent’s offer to provide his medical records regarding his 2011 treatment for Lyme disease. The results of the Board’s investigation are summarized below.

27. Patient 11 had been a patient of the Respondent since approximately 1990 and saw him two or three times each year.

28. The Respondent treated Patient 11 for complaints of pain in her neck, back, shoulder, scapula, flank and lower back.

29. On or about June 13, 2011, Patient 11 was referred to the Respondent by her physician for treatment of thoracic strain. The Respondent treated her for this condition through June 30, 2011.

30. On June 28, 2011, Patient 11 presented to the Respondent for treatment. The Respondent treated Patient 11 in a private room with the door closed. No other individual was present in the room during the June 28, 2011 treatment session.

31. Patient 11 was provided a gown that tied in the back. She was clothed with the exception of her blouse.

32. The Respondent provided hot packs and electrical stimulation before beginning manual therapy.

33. The Respondent documented that on June 28, 2011, he provided connective tissue mobilization, muscle energy exercise, mid-thoracic paraspinals, quadrant stretching and upper thoracic mobilization.

34. Patient 11 told Board staff that during the course of the treatment session, she was lying on her back. The Respondent unhooked her bra. Patient 11 stated that the Respondent typically unhooked her bra for her, having advised her several years earlier that it would be easier for her to breathe because he was working on connective tissue. Patient 11 stated that prior to the June 28 incident, she had trusted the Respondent because she had been treated by him for so long.

35. After Patient 11 received hot packs and electrical stimulation, the Respondent instructed her to stand. Patient 11 complied and stood with her back to the treatment table. The Respondent stood in front of Patient 11 and placed her arms on his shoulders. The Respondent reached over Patient 11 and kneaded her back for a while. Suddenly and without warning, the Respondent grabbed Patient 11's gown and bra and pulled them off. Patient 11 screamed and demanded to know what he was doing.

36. Patient 11 turned away from the Respondent and attempted to retrieve her bra, which he had thrown on the treatment table.

37. The Respondent then came from behind Patient 11, pulled her toward him and started fondling her breasts.

38. After recovering from her initial shock, Patient 11 stepped to the side to avoid the Respondent as her arms are too weakened by previous surgery to otherwise defend herself.

39. The Respondent left the treatment room without speaking.

40. After dressing herself, Patient 11 left the office. She did not see the Respondent or any other employee of the practice as she was leaving.

41. On June 30, 2011, Patient 11 returned to the Respondent. She told Board staff that she had previously scheduled the June 30 appointment, which was the last of a number of pre-authorized visits, and although she had been shocked and very upset by the Respondent's conduct on June 28, she knew that it would take a while for her to find a new PT provider.

42. At the June 30, 2011 appointment, Patient 11 double knotted her gown strings and refused to allow the Respondent untie her gown. He did not unhook her bra. Patient 11 described the Respondent as very subdued during the visit and that he acted as if nothing had happened.

43. Patient 11 did not return to the Respondent after June 30, 2011.

44. Patient 11 told Board staff that prior to the June 28, 2011 incident she had trusted the Respondent and had depended upon him to allow her to continue working. She was troubled and upset that the Respondent would do such a thing to her and told Board staff that it was "really scary" because the Respondent knew her arms and shoulders are weak and "there's not a lot I can do to get away."

45. Patient 11 told Board staff that she did not tell anyone about the Respondent's conduct on June 28, 2011 for a long while because it upset her every time she thought about it and caused her to have nightmares. Patient 11 stated that the Respondent's conduct "makes me sick to this day."

46. Upon inquiry by Board staff regarding the Respondent's conduct prior to the June 28, 2011 incident, Patient 11 recalled that a couple of years earlier, the Respondent had called her on four or five occasions to see what her plans were for the evening. The Respondent had also asked Patient 11 whether she wanted him to treat her at her house and whether he could come to her house to make sure that her garden tools were not a cause of her pain. Patient 11 had refused the Respondent's offers.

47. As stated above, on July 3, 2015, the Respondent telephoned Patient 11 and asked if she had filed a complaint against him. The Respondent did not apologize to Patient 11; he stated that he had been on a twelve-week course of antibiotics to treat Lyme disease which had made him "psychotic." The Respondent further told Patient 11 that he did not remember anything that he had done during that time, but had done things he normally would not do.

48. Patient 11 was upset and shocked by the Respondent's telephone call and believed that he was attempting to get her to reconsider her complaint.

49. When interviewed by Board staff, the Respondent acknowledged that he had called Patient 11 after receiving the Board's subpoena for her records. The Respondent did not think it was inappropriate to contact Patient 11 to determine if she had filed a complaint.

50. The Respondent stated that he called Patient 11 because he wanted to know why she filed a complaint. The Respondent told Patient 11 that he had been affected by Lyme disease and that it "completely turned [his] memory into Swiss cheese."

51. Several weeks after Board staff had interviewed the Respondent, he telephoned Board staff to advise that he had reviewed his medical records regarding his Lyme disease treatment in June 2011. At Board staff's request, the Respondent faxed the records to the Board. The records reveal that the Respondent was diagnosed with "presumptive" Lyme disease in June 2011 and was prescribed antibiotics. The records further reveal that the Respondent was seen by his primary care physician on the morning of June 28, 2011. Notes on June 7 and 24, 2011, document that the Respondent's' judgment and insight were within normal limits and that his recent and remote memory were normal. The June 28, 2011 note did not indicate any change in the Respondent's mental status.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Board concludes as a matter of law that the Respondent. violated Health Occ. § 13-316(14), (15) and (19), and violated those provisions of the Board's Code of Ethics and Sexual Misconduct regulations with which he was charged.

ORDER

It is, on the affirmative vote of a majority of the quorum of the Board, hereby:

ORDERED that the Respondent shall be **SUSPENDED** for one (1) year, all of which shall be **STAYED**; and it is further

ORDERED that the Respondent is placed on probation for a minimum of two (2) years, during which time the Respondent shall:

a) Within thirty (30) days of the effective date of the Consent Order, make an appointment with a Board-approved mental health provider for an evaluation of mental health and boundary issues at the provider's earliest opportunity. Such provider may be licensed in Maryland as a psychiatrist, psychologist or professional counselor (LCPC). The provider shall be provided with a copy of the Consent Order. The provider shall submit an evaluation report to the Board. The Respondent shall comply with any treatment recommendations of the provider, and consent to a release of information between the provider and the Board. The provider shall also provide quarterly reports to the Board for the entire treatment period;

b) For at least the first six (6) months of probation, the Respondent shall have a female chaperone when treating or evaluating any and all female patients. The chaperone shall keep a separate log of her attendance during treatment sessions, which shall include the chaperone's signature for each session attended. The Board may modify this condition based on the results of the evaluation report;

c) For at least the first year of probation, the Respondent shall meet on a monthly basis with a Board-approved documentation expert for the purpose of reviewing the Respondent's clinical documentation and billing records. The expert shall review at least five (5) charts per month that include PTA treatment. The expert shall also reconcile the Respondent's chaperone log with the appropriate treatment records. The expert shall submit quarterly reports to the Board. At the end of one (1) year, the Board, in its discretion, may continue or terminate this condition based on the Respondent's performance and compliance;

d) The Respondent shall successfully complete the next available ethics course tutorial program ("PROBE");

e) Within 60 days of the effective date of the Consent Order, the Respondent shall take the Board's closed book jurisprudence examination with a passing grade of 90%; and it is further

ORDERED that within the first six (6) months of the effective date of the Consent Order, the Respondent shall pay a fine of $5,000 to be paid in full to the Board by certified check or bank guaranteed check made payable to the Maryland State Board of Physical Therapy Examiners; and it is further

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

ORDERED that, if the Board determines, after notice and an opportunity for a hearing, that the Respondent has failed to comply with any term or condition

of this Consent Order, the Board may impose further disciplinary action and/or a monetary penalty. The burden is upon the Respondent to prove his compliance with the Consent Order; and it is further

ORDERED that the Respondent may petition the Board to terminate probation after two (2) years from the effective date of the probation provided that the Respondent has fully complied with the above conditions and no complaints regarding the Respondent are pending before the Board; and it is further

ORDERED that the Respondent shall bear all costs associated with fulfilling the terms of the Consent Order; and it is further

ORDERED that, unless stated otherwise in the Consent Order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect ten (10) days after it is signed by the Board Chair; and it is further

ORDERED that for purposes of public disclosure, as permitted by Md. Code Ann., General Provisions Article § 4-333(b), this document consists of the foregoing Findings of Fact, Conclusions of Law and Order and that the Board may disclose same to any national reporting data bank to which it is mandated to report.

6/13/2016
Date

Krystal Lighty, P.T.
Chair
Maryland State Board of Physical Therapy Examiners

CONSENT

I, Stephen D. Ryan, PT, acknowledge that I have had the opportunity to be represented by counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

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

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

5/16/16
Date

Stephen D. Ryan, PT
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Washington

I HEREBY CERTIFY that on this 16 day of May 2016, before me, a Notary Public of the foregoing State and City/County personally appeared Stephen D. Ryan, PT, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Elysia Fann
Notary Public

My commission expires: 02/12/2018