IN THE MATTER OF	*	**BEFORE THE STATE BOARD**
LYNDA N. SHEALY, P.T.	*	**OF PHYSICAL THERAPY**
License No.: 21872	*	**EXAMINERS**
Respondent	*	**Case Number: PT 20-10 A**

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

CONSENT ORDER

On August 10, 2020, the Maryland State Board of Physical Therapy Examiners (the "Board") charged **LYNDA N. SHEALY, P.T.** (the "Respondent") with violations of certain provisions of the Maryland Physical Therapy Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 13-101 *et seq.* (2014 Repl. Vol. & 2019 Supp.).

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 or restricted license to any applicant, reprimand any licensee or holder of a restricted license, place any licensee or holder of a restricted license on probation, or suspend or revoke a license or restricted license if the applicant, licensee or holder:
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> …
>
> (12) Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy;
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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;
>
> (20) Grossly overutilizes health care services;
>
> …

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

The Board further charged the Respondent with the following violations of the Code of Maryland Regulations (Md. Code. Regs.) 10.38.03.02 – Standards of Practice:

A. Physical Therapists

…

(2) The physical therapist shall:

(a) Exercise sound professional judgment in the use of evaluation and treatment procedures;

(b) Provide:

(i) Physical therapy services to not more than an average of three patients per clinical treatment hour per calendar day, excluding group therapy; and

(ii) Each patient with adequate treatment time consistent with accepted standards in delivering physical therapy care;

…

(e) Evaluate the patient and develop a plan of care before the patient is treated[.]

The Board further charged the Respondent with the following violations of the Code of Maryland Regulations (Md. Code. Regs.) 10.38.03.02-1 – Requirements for Documentation:

A. The physical therapist shall document legibly the patient's chart each time the 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 areas of body treated;
(i) Plan of care including suggested modalities, or procedures, or both, number of visit 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 the 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.

…

(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 October 20, 2020, a conference with regard to this matter was held before the Board's Case Resolution Conference ("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 July 5, 2006. The Respondent's license is scheduled to expire on May 31, 2022.

2. At all relevant times, the Respondent was employed as a P.T. at a skilled nursing facility (the "Facility").[1]

3. On or about October 9, 2019, a national insurance fraud investigatory entity (the "Entity") filed with the Board a report ("the Report") of an investigation it had conducted regarding medical bills submitted by a P.T. co-worker ("P.T. GB") to his insurance company for physical therapy the Respondent had provided to him and two family members after P.T. GB and the family members were involved in a motor vehicle accident.[2]

4. Upon receipt of the Report, the Board initiated an investigation. In furtherance of the investigation, the Board obtained the medical bills and associated treatment notes submitted by P.T. GB to his insurance company (the "Insurance Company") and transcripts of interviews conducted by the Entity's investigators. Board staff interviewed under oath the Respondent, P.T. GB, one of P.T. GB's family members, and the Respondent's former supervisor. The Board also referred the Respondent's

[1] To maintain confidentiality, the names of all witnesses, facilities, patients, and other individuals will not be used in this document.

[2] When interviewed by Board staff, P.T. GB stated that he once owned his own P.T. company and had employed the Respondent as the "V.P. of operations…she was over top of all of our managers." He also identified the Respondent as a friend of his family.

treatment notes to a P.T. (the "Expert") for review. The results of the Board's investigation of the Respondent are summarized below.[3]

A. The Entity's Investigation

5. On February 23, 2019, the car in which P.T. GB and two family members were riding was rear-ended by another vehicle. The accident was not severe and P.T. GB's car sustained only minor damage.

6. On or about March 22, 2019, P.T. GB submitted to the Insurance Company invoices for physical therapy provided by the Respondent to him and the two family members. P.T. GB was seeking payment for the invoices from his insurance policy's Personal Injury Protection ("PIP") coverage.

7. The address on the invoices submitted by P.T. GB was the Facility where both the Respondent and P.T. GB were then employed; however, the name of the billing entity was "[the Respondent's last name] Rehab." The business identification number on the invoices was the number associated with the Facility.

8. The invoices revealed that the Respondent provided identical treatment to P.T. GB and his family members on 10 occasions from February 27, 2019 through March 18, 2019. The total amount of all three invoices was also identical - $2,510.23.

9. The Respondent told an Entity investigator that P.T. GB's PIP coverage was "only for $2,500" [for each family member], "[s]o they didn't want to pay out-of-pocket and we cut it [treatment] then."

[3] The Board also charged P.T. GB with violations of the Act related to this case.

10. When questioned by the Entity investigator, the Respondent and P.T. GB stated that the Respondent had provided the physical therapy at the Facility "after hours."

11. When questioned, the Respondent and P.T. GB's supervisor at the Facility told Investigators that no one would be permitted to obtain physical therapy at the Facility unless they were a Facility patient.

12. The supervisor denied giving P.T. GB or the Respondent permission for the Respondent to treat P.T. GB and his family members at the Facility.

13. On or about April 1, 2019, P.T. GB withdrew his PIP claim.

14. The Facility terminated the Respondent and P.T. GB's employment in or around April 2019.

B. The Board Investigation

15. When interviewed under oath by Board staff, both the Respondent and P.T. GB stated that the Respondent had treated P.T. GB and his family members in the basement of the family's home, not the Facility as they had told the Entity investigator.

16. The Respondent stated that she was "caught off guard" when she was interviewed by the Entity investigator when she stated that she had provided the treatment at the Facility. The Respondent further stated, "[l]ike, this just has totally spiraled into something that I had no clue I was going to get into."

17. When Board staff asked the Respondent why she did not correct his misstatement, she responded, "[the Entity investigator] had papers saying that that's was [sic] happened, so I was just like, you know, honestly, I didn't know what to do."

18. When interviewed by Board staff, P.T. GB stated that the Respondent "knew nothing about the billing processes" so she gave her handwritten treatment notes to him for transcription by one of his family members. P.T. GB further stated that he sent the transcribed notes to "a lady who I knew did outpatient billing." P.T. GB then transmitted the invoices to the Insurance Company.

19. P.T GB confirmed that he requested the insurance company to send the PIP funds directly to him because the Respondent was "pushing" him to get paid.

20. When Board staff queried the Respondent regarding payment, she stated, "we never discussed payment. Like, I was just being a friend and doing this. Like, it was never payment discussed [sic]… this was just, like, an experience type of thing. There was never a discussion about payment."

C. The Expert's Review

21. When interviewed by Board staff, the Respondent stated that she had thrown out her handwritten notes. P.T. GB had told Board staff that one of his family members had transcribed the Respondent's treatment notes, "word for word because [the family member] is not a therapist, so she has to write down what she sees."

22. The Board's Expert reviewed the Respondent's transcribed treatment notes and found the documentation to be deficient.

23. The Expert found that, “in all notes, evaluations and treatments for all three patients, total timed treatment and total treatment time were not documented, therefore it cannot be determined whether billing for any of the CPT codes is correct.”[4]

24. The Expert further opined, “in each case, evaluation provided insufficient information on patients’ current condition and status and did not provide enough information for another treating therapist to replicate and provide appropriate treatment based on the documentation.”

25. The Experts found that “evaluations provided scant information on U[pper] E[xtremity] strength, but no additional information provided on palpation, ROM [range of motion], objective measures and functional limitations.”

26. When interviewed by Board staff the Respondent acknowledged that she estimated the measurements she did document and did not use any gauges.

27. The Expert’s findings of her review of the Respondent’s treatment notes include, but are not limited to:

a) the Respondent failed to document a diagnosis for which the patients are being treated;

b) the Respondent failed to document the onset of the condition for which the patients were treated;

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[4] The treatment invoices for the Respondent and his family members are identical. At each visit the following modalities and procedures were billed: electrical stimulation; myofascial release; neuromuscular re-education; and moist heat application.

c) the Respondent's documentation of patient histories is "grossly limited" and fails to include general demographic information;

d) the evaluation for all three patients is "grossly limited" to gross measurement of upper extremities. The Respondent's evaluations fail to contain sufficient information to determine a plan of care;

e) the Respondent failed to assess or interpret findings and failed to summarize the patients' impairments and functional limitations;

f) the Respondent failed to document therapy goals that are measurable and functional and have a temporal component;

g) the Respondent billed for two units of Manual Therapy (noted on the invoices as Myofascial Release) at each visit, however, neither Manual Therapy nor Myofascial Release is documented in the Plan of Care;

h) the Respondent failed to document an adequate discharge note;

i) the Respondent failed to document her license number on all of the treatment notes.

28. The Respondent's conduct, in whole or in part, constitutes violations of Health Occ. § 13-316 (12), (14), (15), (19), (20) and (25). The Respondent's conduct also violates the Board's standard of practice and documentation regulations with which she was charged.

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 (12), (14), (15), (19), and (20), and the Board's regulations under which the Respondent was charged.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum of **ONE (1) YEAR;** and it is further

ORDERED that during the probationary period, the Respondent shall comply fully with the following terms and conditions:

(1) Within the first six (6) months of probation, the Respondent shall complete at least six (6) hours of Board-approved continuing education. Three (3) of the continuing education hours shall be in ethics and three (3) shall be in preventing fraud and abuse; none of which shall count towards the continuing education hours required for licensure renewal;

(2) Within the first six (6) months of probation, the Respondent shall successfully pass the Board's closed-book law examination with a passing score of 90 percent; 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 failure to comply fully and satisfactorily with the terms and conditions of the Consent Order shall constitute a violation of probation; 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

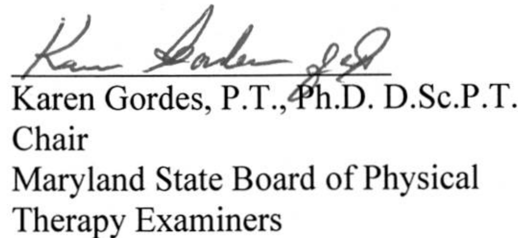
ORDERED that the Respondent may petition the Board to terminate probation after a minimum of one (1) year provided that the Respondent has fully complied with the above conditions and no complaints regarding the Respondent are pending before the Board; and it is further

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. 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.

3/22/21
Date



Karen Gordes, P.T., Ph.D. D.Sc.P.T.
Chair
Maryland State Board of Physical
Therapy Examiners

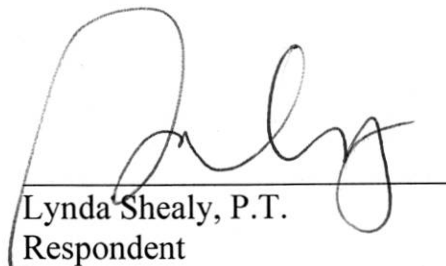
CONSENT

I, Lynda Shealy, P.T., 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.

3/13/2021
Date



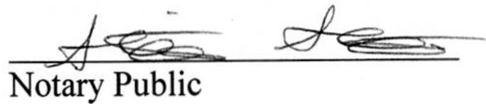
Lynda Shealy, P.T.
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Anne Arundel

I HEREBY CERTIFY that on this 13 day of March ~~2020,~~ 2021 before me, a Notary Public of the foregoing State and City/County personally appeared Lynda Shealy, P.T., and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Stephanie Rose Stapf
Notary Public
Anne Arundel County, Maryland
My Commission Expires August 13, 2024



Notary Public

My commission expires: 08/13/2024