IN THE MATTER OF	*	**BEFORE THE**
MELISSA TOBIN, D.C.	*	**STATE BOARD**
LICENSE NO. S01531	*	**OF CHIROPRACTIC EXAMINERS**
Respondent	*	

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

FINAL CONSENT ORDER

Based on information received and a subsequent investigation by the State Board of Chiropractic Examiners (the "Board"), and subject to Md. Health Occ. Ann. § 3-101, et seq., (2000 Repl. Vol.) (the "Act"), the Board charged Melissa Tobin, D.C., (the "Respondent"), with violations of the Act. Specifically, the Board charged the Respondent with violation of the following provisions of § 3-313:

> (a) Subject to the hearing provisions of § 3-315[1] of this subtitle, the Board may deny a license to any applicant, reprimand any licensee, place any

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1 **§3-314 Penalty instead of suspension or in addition to suspension or revocation.**

> (a) If after a hearing under § 3-315 of this subtitle the Board finds that there are grounds under § 3-313 of this subtitle to suspend or revoke a license, the Board may impose a penalty not exceeding $5,000 for each violation:
>
> (1) Instead of suspending the license; or
>
> (2) In addition to suspending or revoking the license.
>
> (b) If, after disciplinary procedures have been brought against a licensee, the licensee waives the right to a hearing required under this subtitle and if the Board finds that there are grounds under § 3-313 of this subtitle to reprimand the licensee, place the licensee on probation, or suspend or revoke a license, the Board may impose a penalty not exceeding $5,000 for each violation in addition to reprimanding, placing the licensee on probation or suspending or revoking the license.

licensee on probation, or suspend or revoke a license if the applicant or licensee:

(8) Is unethical in the conduct of the practice of chiropractic;

(12) Willfully makes or files a false report or record in the practice of chiropractic;

(16) Grossly and willfully:

(i) Overcharges for professional services; or

(ii) Submits false statements to collect fees for which services are not provided;

(18) Practices chiropractic with an unauthorized person or supervises or aids an unauthorized person in the practice of chiropractic;

(19) Violates any rule or regulation adopted by the Board;

(21) Commits an act of unprofessional conduct in the practice of chiropractic;

(22) Grossly overutilizes health care services;

(25) Submits false statements to collect fees for which services were not provided [;].

The Board further charges the Respondent with violating its Chiropractic Assistants Regulations, Code Md. Regs. tit. 10, § 43.07 (2000). Specifically the Board charges the Respondent with violating the following subsections:

.01 Definitions

B. Terms Defined.

(5) "Supervising chiropractor" means a chiropractor licensed by the Board in chiropractic with the right to practice physical therapy as set

forth in Health Occupations Article, § 3-301(c), Annotated Code of Maryland.

.02 Board Approval Required.

A. A supervising chiropractor shall apply for and receive approval from the Board before undertaking to train or supervise a new applicant or chiropractic assistant.

06. Responsibilities of the Supervising Chiropractor.

A. The supervising chiropractor is responsible for the safe and competent performance of the assigned duties of the applicant and the chiropractic assistant.

07. Supervision Requirements.

A. The Supervising chiropractor shall ensure that a chiropractic assistant or an applicant performs the authorized procedures or activities under the direct supervision of a licensed chiropractor.

The Respondent was given notice of the issues underlying the Board's charges by notice dated July 29, 2002. Accordingly, a Case Resolution Conference was held on October 10, 2002, and was attended by Paula Lawrence, D.C., Board member, and Richard Bloom, Counsel to the Board. Also in attendance were the Respondent and her attorney, Marc K. Cohen, and the Administrative Prosecutor, Roberta Gill.

Following the Case Resolution Conference (CRC), 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

1. At all times relevant to the charges herein, the Respondent was licensed to practice chiropractic in the State of Maryland. The Respondent was first licensed on December 5, 1990. The Respondent's license expires September 1, 2003. The Respondent is a supervising chiropractor, which means that she is able to supervise chiropractic assistants.

2. The Respondent owns two chiropractic offices: one is located on Erdman Avenue in Baltimore City; the other is located in Glen Burnie, in Anne Arundel County. During most of the times relevant herein, the Respondent provided the chiropractic care at the Erdman Avenue office, and she employed or used the services of an independent contractor to provide chiropractic care at the Glen Burnie office. During most of the times relevant herein, there were certified chiropractic assistants at each office.

3. The chiropractors at the Respondent's offices use a travel card, which is a sheet of paper on which the doctors wrote billing codes and a short space for inscribing SOAP[2] notes. The Respondent would change billing codes frequently and they did not necessarily correspond to those used by the Current Procedural Terminology ("CPT") codes. This card travels with the patient while the patient is receiving services, e.g., it is

2 SOAP=Subjective complaints; Objective observation by the practitioner; Assessment or physical examination/diagnosis; and Plan (treatment plan). While the word SOAP does not have to appear, the treatment notes should follow this format.

supposed to be marked by the practitioner whenever the patient received treatment. Information is taken from the travel card to be entered into the computer for billing purposes.

4. In addition to the travel card, a statement card is maintained on each patient. A clerk transcribes the billing code used on the travel card onto the statement card, along with the date of service and the procedure. The statement card is then given to the billing clerk to enter information into the computer for billing purposes/collecting co-payments.

5. Billing for both the Erdman Avenue office and the Glen Burnie office was done at the Glen Burnie office. The Respondent billed for services rendered at the Erdman Avenue office. During most of the times relevant herein, M.G.[3] handled the billing of health insurance claims, out-of pocket and co-pay payments for treatment rendered at the Glen Burnie office. During most of the times relevant herein, D.J. handled billing for personal injury and workers compensation claims for treatment rendered at the Glen Burnie office.

6. During a substantial portion of the time relevant herein, Dr. L.S., a chiropractor, provided chiropractic treatment at the Glen Burnie office. Dr. L.S. initially began working for the Respondent as an employee; in 1998, Dr. L.S. became an independent contractor. While working for the Respondent, Dr. L.S. was not a supervising chiropractor. Dr. L.S. opened his own practice in the Fall of 1998, down the street from the

3 Neither patients' nor employees' nor chiropractors' names will be disclosed in this document; however, the Respondent is aware of their identities.

Respondent. Many of the Respondent's patients transferred to Dr. L.S. Also, one of the Respondent's employees, whom he later married, began working for Dr. L.S.

7. After Dr. L.S. left in November 1998, the Respondent hired Dr. T.F., a chiropractor, to provide treatment in her Glen Burnie office.

8. The Respondent's Glen Burnie office consisted of D.J., office manager, who for a time, allowed her registration to practice as a chiropractic assistant to lapse; T.M., a registered chiropractic assistant; and, S.S., a registered chiropractic assistant.

9. R.C., a registered chiropractic assistant, worked at the Respondent's Erdman Avenue office. For one month in 1999, Dr. P.E., a chiropractor, supervised her. Dr. P.E. is not an authorized supervising chiropractor. At all other times during R.C.'s employment at that office, the Respondent supervised her.

ALLEGATIONS WITH RESPECT TO THE COMPLAINANT

10. Dr. L.S. treated the Complainant from June 6, 1997 to October 28, 1998, at the Respondent's Glen Burnie office. The Complainant alleged that she was overbilled. The Complainant alleged that she had received copies of the Respondent's billing for her treatment at the Glen Burnie office from her insurance carrier and that she was "stunned" by what the Respondent claimed she owed. Consequently, the Complainant indicated that she had requested a copy of her treatment records from the Respondent, but that the Respondent refused to give her a copy of her records.[4]

4 The Respondent finally provided a copy of the Complainant's treatment records to the Complainant two

11. Based upon that complaint, the Board began an investigation by requesting the complainant's patient treatment records from the Respondent.

12. When the Respondent hand-delivered the subpoenaed files to the Board, she informed the Board's investigator that Dr. L.S. had been the sole treating doctor and that he had been solely responsible for prescribing the frequency of treatment, the modality used and the services to be billed for all patients he treated. The Respondent further informed the investigator that, after reviewing the Complainant's records, she felt that the treatments were the usual ones that other patients received and that the bill is customary for those treatments.

13. The Respondent billed the Complainant's insurer for 93 visits. A comparison of the treatment that Dr. L.S. had written in the record that he provided to the Complainant with that billed by the Respondent discloses that the Respondent billed additional procedures for 24 office visits. For instance, on June 4, 1997, the patient records indicated a manipulation charge of $40: in addition to the manipulation, the Respondent billed $20 each for electrical stimulation and traction procedures that were not performed, resulting in an overcharge of $40.

ALLEGATIONS WITH RESPECT TO OTHER GLEN BURNIE PATIENTS

14. After examining the Complainant's record, the Board subpoenaed additional patient files from the Respondent's Glen Burnie office. Of the fifteen (15) files that the

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weeks after the Complainant filed her complaint with the Board.

Board obtained, in thirteen (13) of those, the Respondent billed for procedures not documented in the patients' records, or the Respondent was not able to substantiate the billing, e.g., billed for x-rays that were not produced.[5] A review of those files disclosed the following:

15. Patient A received treatment at the Respondent's practice from October 30, 1996 to April 7, 1997. Patient A' s treatment record indicated that joint mobilization and kinetic activities were rendered, but Patient A's billing record indicated that Patient A was billed for chiropractic manipulation, myofascial release and electrical stimulation. The Respondent billed procedures not rendered by the treating doctor for eight of Patient A's fifteen (15) office visits. For example, the travel card indicated that, on January 6, 1997, the treating doctor had performed joint mobilization, at the rate of $40, and kinetic activities, at the rate of $35. However, the Respondent billed for re-examination at the rate of $75; manipulation at $35; myofascial release at the rate of $30; traction at the rate of $20; and, electrical stimulation at the rate of $20, resulting in an overbilling of $105. The Respondent acted unprofessionally in failing to ensure that the patient was properly billed.

16. Patient C[6] was treated in the Respondent's practice from February 21 to July 10, 1996. The Respondent billed Patient C's insurer 18 visits that did not appear on Patient B's travel card in the treating doctor's writing: the travel card notations were written

5 At the CRC, the Respondent indicated that she had located some x-rays or documentation regarding x-rays billed, which she had not been able to produce when initially requested.
6 By agreement of the parties, some of the patients, identified in the charging document alphabetically in sequence, do not form the basis of the Consent Order.

by the Respondent's billing staff, and it appeared to be based on non-contemporaneous SOAP notes prepared by the treating doctor, which were inconsistent with the office sign-in sheets and appointment books. The Respondent was unprofessional in failing to properly train and instruct the office administrative staff and professional staff with respect to creation and maintenance of proper records and in generating patient charges not documented in the patient record.

17. Patient D was treated at the Respondent's Glen Burnie office from February 13 to April 1, 1997. For six of Patient D's seven visits, the Respondent billed for additional procedures, totaling $125.

18. Patient F was treated at the Respondent's Glen Burnie office for 60 office visits from September 24, 1995 to December 29, 1998. However, no patient file was located, but the patient's insurer was billed for these visits.

19. Patient G was treated on 10 occasions at the Respondent's Glen Burnie office from March 27 to June 5, 1997. The Respondent was not able to produce a travel card or statement card for the billing she rendered.

20. Patient H was treated at the Respondent's Glen Burnie office from January 3, 1996 to August 7, 1998. Of Patient H's 78 visits, Patient H was billed for sixteen (16) more procedures than were documented in the patient record, resulting in an overcharge of $2455. The billing or ledger card indicates correction to the account written by the Respondent's billing clerk. In those instances, there was no entry in the original travel

card; no SOAP notes; no signature in the patient sign-in sheet; and, no cash receipts for co-pays. The Respondent was unprofessional in permitting her staff to create and submit bills without professional oversight and in causing such bills to be submitted, which were inconsistent with the patient record.

21. Patient I was treated at the Respondent's Glen Burnie office 63 times from December 22, 1994 to June 22, 1998. The Respondent could not produce a patient chart for the Respondent indicating what procedure, if any, Dr. L.S. performed.

22. Patient K was treated at the Respondent's Glen Burnie office from October 17, 1995 to February 10, 1999. For 17 of Patient K's 51 visits, the Respondent billed for procedures not documented as rendered by the treating doctor.

23. Patient L was treated at the Respondent's Glen Burnie office from February 21 to March 25, 1997. For each of Patient L's five visits, the Respondent billed for additional procedures than were not documented by the treating doctor.

24. Patient M was treated at the Respondent's Glen Burnie office from January 1, 1994 to June 10, 1999. Prior to January 20, 1997, the Respondent failed to produce either a SOAP note, travel card or statement card to crosscheck the patient record. The Respondent acted unprofessionally in failing to supervise and train her staff to avoid the loss of these records.

ALLEGATIONS REGARDING THE RESPONDENT'S FAILURE TO SUPERVISE ASSISTANTS

25. R.C., a chiropractic assistant working at the Respondent's Erdman Avenue office, was permitted to treat patients without supervision between December 1996 and April 1997. For those patients, the Respondent billed for some procedures which only a chiropractor can perform. The Respondent, in permitting such actions, aided the unauthorized practice of chiropractic.

26. On or about January 2, 2001, the Board received information that Dr. L.S.'s malpractice insurer had settled a claim. Upon further investigation, the Board determined that the claim was a result of a burn alleged to have occurred because D.J., an unregistered chiropractic assistant, left the electrical stimulation/heating pad on for too long on the patient's back. The patient was treated at the Respondent's Glen Burnie office, where Dr. L.S. provided all the treatment and directed the assistants. However, Dr. L.S. was not a supervising chiropractor at the time of the incident. The Respondent failed to properly ensure that all certificates, licenses and/or registrations for staff persons were active or in effect, prior to allowing them to perform duties requiring such certification, licensure or registration.

ALLEGATIONS WITH REGARD TO EMPLOYEE TREATMENTS

27. The Respondent required or urged her employees to undergo chiropractic treatment in her office. The Respondent failed to keep proper records with regard to these individuals. In so doing, the Respondent engaged in unprofessional conduct in requiring or encouraging her staff to receive these treatments.

28. Specifically, between February and August 1999, the Respondent's office provided treatments to a number of its staff and relatives of its staff. The documentation with regard to this treatment was non-contemporaneous; SOAP notes were missing and, often, when present, were not prepared by the Respondent, the treating doctor, but were prepared by the patient (the Respondent's chiropractor-employees). Treatments noted and bills rendered were often inconsistent. The Respondent acted unprofessionally with regard to permitting charges to be billed that were not found in the patient record.

29. For example, Dr. T.F., who replaced Dr. L.S. when he left, examined the treatment records of E.F.-1 and E.F.-2 (Dr. T.F.'s daughters). The Respondent had billed for their treatment a total of 23 occasions from April 26 through June 28, 1999. Dr.T.F. had performed all of the treatment rendered to them, but had only treated them on six occasions. The Respondent billed for procedures not documented by the treating doctor, resulting in an overbilling of $1370.

30. Dr. T.F. also examined the patient records of his wife, P.F., whom the Respondent had billed his insurer for 31 treatments, from April 26 through June 28, 1999.

Dr. T.F. stated that he had only treated P.F. a maximum of 20 times. The Respondent overbilled the insurer $1190.

31. Dr. T.F. also examined his own patient records. The Respondent had billed his insurer from April 24 through June 28, 1999 for 32 treatments. However, the Respondent had only treated him six times and had told Dr. T. F. that he was required to write his own SOAP notes for treatment billed to his insurer. The Respondent billed for procedures not documented, overbilling the insurer by $4000.

32. Dr. T.F. examined M.G.'s patient records. Between February 11 and July 5, 1999, the Respondent had billed employee/patient M.G.'s insurer for 64 treatments. Dr. T.F. stated that he had only adjusted M.G. once a week during that period, or 22 of those 64 times. Dr. T.F. further stated that he did not provide any other treatments, although the Respondent billed M.G.'s insurer for additional treatments, such as electrical stimulation. Dr. T.F. noted that on February 15, 1999, his SOAP note indicates that he manipulated three to four regions of M.G.'s spine, but the Respondent billed the insurer for five regions. M.G. confirmed these statements. Based upon these statements, the Respondent overbilled M.G.'s insurer by $5390.

33. Similarly, Dr. L.S. also stated that the Respondent had mandated that he receive treatments at her office. Dr. L.S. confirmed that the Respondent required him to write treatment notes for all occasions billed for his own treatment, even though he may not have received all of the treatments billed.

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Board finds that the Respondent violated §§ 3-313 (12), (18), (21), and (25) of the Act. The Board makes no findings with regard to the other violations cited.

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 14th day of November 2002, by a majority of a quorum of the Board,

ORDERED that the Respondent is **REPRIMANDED**; and be it further

ORDERED that the Respondent pay a monetary fine of Ten Thousand Dollars ($10,000) to the Board within six weeks of the effective date of this Order; and be it further

ORDERED that the Respondent be placed on **PROBATION** for one year, subject to the following conditions:

1. The Respondent shall take and pass a Board-pre-approved ethics course and submit documentation of the completion of same to the Board;

2. The Respondent shall take and pass a Board-pre-approved records-keeping course and document the completion of same to the Board;

3. The Respondent shall submit to random review of her files by a Board-approved expert; and,

4. The Respondent shall continue in regular counseling with her therapist, who shall provide to the Board reports of her status/progress to the Board six months from the commencement of the Probation and one year from the commencement of the Probation.

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's practice is a threat to the public health, welfare and safety, the Board may take immediate action against the Respondent, including suspension or revocation, providing notice and an opportunity to be heard are provided to the Respondent in a reasonable time thereafter. Should the Board receive in good faith information that the Respondent has substantially 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 chiropractic in Maryland; and be it further

ORDERED that, at the end of the Probationary period, the Respondent may petition the Board to be reinstated without any conditions or restrictions on her license, provided that she 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. Should the Respondent fail to petition the Board, the conditions of Probation will remain the same;

ORDERED that for purposes of public disclosure, as permitted by Md. State Gov't. Code Ann. §10-617(h) (Repl. Vol. 1999), 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 or report same in its newsletter.

Jack L. Murray, Jr., President
State Board of Chiropractic Examiners

CONSENT OF MELISSA J. TOBIN, D.C.

I, Melissa J. Tobin, D.C., by affixing my signature hereto, acknowledge that:

1. I am represented by an attorney, Marc K. Cohen, and have been advised by him of the legal implication of signing this Consent Order;

2. I am aware that without my consent, my license to practice chiropractic in this State cannot be limited except pursuant to the provisions of § 3-313 of the Act and the Administrative Procedure Act (APA) Md. State Govt. Code Ann. §10-201, et seq., (1999 Repl. Vol.).

3. I am aware that I am entitled to a formal evidentiary hearing before the Board

By entering into this Consent Order, the Respondent neither admits nor denies the foregoing Findings of Fact, conclusions of law, but does voluntarily enter into and consent 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 § 3-315 of the Act and §10-201, et seq., of the APA, and any right to appeal as set forth in § 3-316 of the Act and §10-201, et seq., of the APA. I acknowledge that by failing to abide by the conditions set forth in this Order, I may, after an opportunity to be heard, pursuant to the APA, suffer disciplinary action, including revocation, against my license to practice chiropractic in the State of Maryland.

11/12/02
Date

Melissa J. Tobin, D.C.

STATE OF MARYLAND

CITY/~~COUNTY~~ OF BALTIMORE :

I HEREBY CERTIFY that on this 12th day of NOVEMBER, 2002, before me, DELIGHT HERMAN (Print Name) a Notary Public of the foregoing State and (City/~~County~~), personally appeared Melissa J. Tobin, License No. S01531, 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.

Dwight Herman
Notary Public

My Commission Expires: _____

DELIGHT HERMAN
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires December 17, 2005