

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

PUBLIC HEALTH HEARING SECTION

June 13, 2011

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VIA EMAIL
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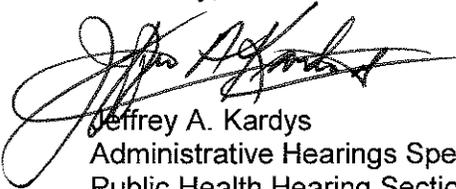
Inter-Departmental Mail

RE: Sharon Weiselfish-Giammatteo, P.T. - Petition No. 2005-0104-014-001

Dear Attorney Kogut and Attorney Antonetti:

Enclosed please find a copy of the Memorandum of Decision issued by the **Connecticut State Board of Examiners for Physical Therapists** in the above-referenced matter.

Sincerely,



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Administrative Hearings Specialist/Board Liaison
Public Health Hearing Section

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**STATE OF CONNECTICUT
CONNECTICUT STATE BOARD OF EXAMINERS
FOR PHYSICAL THERAPISTS**

Sharon Weiselfish-Giammatteo, P.T.
License No. 002852

Petition No. 2005-0104-014-001

MEMORANDUM OF DECISION

Procedural Background

On September 14, 2006, the Department of Public Health ("the Department") presented the Connecticut State Board of Examiners for Physical Therapists ("the Board") with a Statement of Charges ("Charges"). The Statement of Charges alleges violations of certain provisions of Chapter 376 of the General Statutes ("the Statutes") by Sharon Weiselfish-Giammatteo ("respondent"), which would subject her physical therapy license to disciplinary action pursuant to §§ 19a-17 and 20-73a of the Statutes.

On October 16, 2006, the Department sent a Notice of Hearing ("the Notice") and a copy of the Charges to respondent by certified mail, return receipt requested. The Notice directed the respondent to appear before the Board for a hearing on the Charges on January 10, 2007. The Board was compromised of Christine J. Kasinskas, P.T., Chairperson, Joan Grey, P.T., Mary Lou Sanders, public member and Krystyna Piotrowska, M.D.

On February 28, 2007, the respondent filed an Answer to the Charges. The Department filed a Motion to Amend the Charges dated February 28, 2007.

After one continuance, the hearing was scheduled for March 12 and 15, 2007. The respondent appeared with her attorney, Michael Kogut, and the Department appeared through its attorney Joelle Newton.

On the first day of hearing on March 12, 2007, the Board granted the Department's Motion to Amend the Charges, absent objection from the respondent. Tr., 3/12/07, pp. 4-5. The respondent filed a First Amended Response to the Charges and a Motion in Limine to Exclude Complaint of patient #1.¹ The Board admitted the complaint as a Department Exhibit and advised the respondent that she could question patient #1 regarding this complaint should she

¹ Patient #1 also known as BK filed a complaint with the Department concerning treatment provided to her by the respondent.

wish to do so. Tr. 3/12/07, p. 19; Dept. Exh 1, Tab 14. The Respondent then orally moved to disqualify attorney Newton claiming that attorney Newton placed herself in the position of being a perspective witness in this proceeding based on her interviewing one of the respondent's employees at respondent's place of business. This motion was denied. Tr. 3/12/07, pp. 22-28. Kathleen Zettergren, P.T., Ed.D., testified as an expert witness on behalf of the Department, and, she was cross-examined by respondent's counsel.

On March 13, 2007, the Department filed a second Motion to Amend the Charges, which was granted by the Board on March 15, 2007. Tr. 3/15/07, p. 7. The respondent filed a Motion for Subpoena and Order for Deposition of patient #1. As discussed more fully below, this motion was later denied without prejudice.

At the hearing on March 15, 2007, the testimony of Ms. Zettergren concluded² and Mark Schooley, the Chief Financial Officer of Regional Physical Therapy testified. Tr. 3/15/07, p. 7. Respondent reserved her cross-examination of Mr. Schooley until the presentation of her defense. Tr. 3/15/07, pp. 207-08.

A Notice of Hearing was issued thereafter scheduling hearing dates for April 5, 2007, May 7, 2007, June 26, 2007, June 28, 2007 and June 29, 2007.

On April 2, 2007, Attorney William Gallitto, on behalf of Desert Light Health Associates, filed a Motion to Quash a Subpoena that was issued by the Department, seeking records from Desert Light Health Associates concerning patient #1.

At the start of the hearing on April 5, 2007, the Board disclosed on the record to the respondent and her counsel that after the hearing concluded on March 15, 2007 an ex-parte communication occurred between Board member Christine Kasinskas and Attorney Newton regarding which witnesses the Department should call to testify at the next hearing date. At the respondent's request, the Board continued the hearing to allow the respondent to file any briefs and/or motions as a result of this communication.

On April 17, 2007, the respondent filed a Motion for Termination of Proceedings. This motion sought to disqualify Attorney Newton from this proceeding and any future proceedings before the Board. In addition, this motion sought a termination of the proceedings before the Board and requested that the proceedings before the Board begin "anew". The Department filed

² With respect to this witness, cross-examination, redirect examination, and recross-examination occurred at the hearing on March 15, 2007.

an Objection to this motion on April 24, 2007. On April 26, 2007, the respondent filed a Reply to the Department's Objection and a Motion for Subpoena, requesting, among other things, that the Board issue a subpoena for the testimony of Attorney Newton. The Department filed a Reply to Respondent's Reply to the Department's Objection, and an Objection to the Motion for Subpoena dated May 3, 2007.³ Thereafter, the respondent filed a Renewed Motion for Termination of proceedings dated May 3, 2007 and the Department filed a Reply thereto dated May 8, 2007.⁴ On September 25, 2007, the respondent filed a Clarification of Position Regarding Motions for Termination of Proceedings, indicating that she was seeking a new hearing before a new Board to hear evidence and adjudicate the Charges. The Department filed a response to respondent's Clarification on September 26, 2007.

On November 6, 2007, the Board issued a Notice of Hearing Postponement advising the parties that the November and December, 2007 hearing dates were canceled based on the resignation of Dr. Piotrowska and anticipated resignation of other Board members. The parties were advised that future hearing dates and rulings on the pending motions would occur after the vacancies were resolved. Thereafter, Board members Kasinaskas and Grey resigned from the Board.

The undersigned, Sandra Worrell, public member, Lise Van Saun, P.T., Andrea O'Brien, P.T. and Robert J. Carr, M.D., were then appointed by the Governor to serve on this Board. Board member Mary Lou Sanders was recused from participating in this proceeding.

On June 3, 2008, the Board issued a Ruling with respect to the pending motions. The Board granted in part/denied in part the respondent's Motion for Termination of Proceedings. The Board granted the respondent a new hearing with a new record before a new Board but

³ On May 1, 2007, the Department through its new legal counsel Attorney Matthew Antonetti filed a motion for continuance of the May 7, 2007 hearing, which was not objected to by respondent. The Board granted the motion for continuance on May 3, 2007.

⁴ The respondent filed a Motion for Continuance of the June 29, 2007 hearing, which was granted by the Board. On June 20, 2007, the Department and the respondent filed a joint request for continuance of the June 26 and 28, 2007 hearing dates to pursue settlement negotiations. The joint motion noted that it was anticipated that a settlement may be presented to the Board for its approval at the next Board meeting. The Board granted the joint request and advised the parties if a consent order was not presented to the Board at its next meeting on September 16, 2007, then new hearing dates would be scheduled. On September 20, 2007, the Board issued a Notice of Hearing scheduling hearing dates for November 1, 8, 15, 16 and 29, 2007 and December 6, 7, 11, and 14, 2007. On September 26, 2007, the respondent filed a request for continuance of the November 1 and 29, 2007 hearing dates, which was granted by the Board. On November 5, 2007, the respondent filed a request for continuance of the November 8, 2007 hearing.

denied as moot respondent's request to disqualify Attorney Newton since Attorney Antonetti replaced her as legal counsel for the Department. The Board denied the respondent's request to subpoena Attorney Newton on the grounds that any testimony she may have had would be irrelevant to the charges at issue and would serve no useful purpose in adjudicating the Charges pending before the Board. The Board also denied without prejudice the Motion for Deposition and Motion to Quash Subpoena since the Board was terminating the proceeding and providing the respondent with a new hearing. The Board noted that these motions could be refilled, if necessary, during the new proceeding.

On June 3, 2008, the Board also issued a Notice of Hearing scheduling hearing dates for July 10, 2008, September 16, 2008, September 30, 2008, October 7, 2008, October 21, 2008, November 4, 2008, and November 18, 2008. On June 12, 2008, the respondent filed a Request for Continuance, seeking a continuance of the first three scheduled hearing dates. This motion was granted by the Board.

On July 17, 2008, the Department filed a Request for Modification of Portion of the Board's Ruling, in the Alternative Introduction of Transcripts of Witness Testimony and Previously Accepted Documentary Evidence in the Administrative Record, stating that the Board in its June 3, 2008 Ruling deviated from the provisions of the Uniform Administrative Procedure Act (UAPA) by holding that the Board will provide the respondent with a "new record." On August 6, 2008, the respondent filed an Objection thereto and a Request for Hearing on the Department's Request for Modification. On September 25, 2008, the Board issued a Ruling, clarifying that when the Board indicated that the respondent would be provided with a "new record," the Board meant a new *evidentiary record*. The Board noted that for purposes judicial review, the administrative record would include all the prior Board, Department and Respondent's exhibits entered by the previous Board members⁵, all of the transcripts, motions and objections by the parties filed before the previous Board, as well as any exhibits, transcripts, rulings and motions, etc. filed with this new Board. The Board further noted that its prior decision did not preclude the parties from offering as evidence any prior exhibits or transcripts in the new proceeding, subject to objection by the opposing party and ruling by the Board.

⁵ The exhibits before the former Board included Department Exhibits 1 through 6, Board Exhibits 1 through 7, and Respondent Exhibit A.

At the hearing on October 7, 2008, Attorney Michael Kogut represented the respondent and attorney Matthew Antonetti represented the Department. The Department entered various exhibits, including the transcripts of Dr. Zettergren's and Mr. Schooley's testimony from the prior hearing and patient #1's treatment records. The Department then rested its case, reserving questioning of the respondent until she testified in her defense.

On October 14, 2008, respondent filed a Motion to Dismiss or, in the Alternative, a Motion for a Mistrial, to which the Department filed an objection on October 20, 2008. The respondent's Motion was denied by the Board on February 10, 2009.

Hearings were held on October 21, November 4 and 8, 2008, and February 3 and 10, March 3, June 2 and November 3, 2009, during which time the respondent presented her defense. The respondent presented the testimony of three physical therapists, Kristen Godikesen, P.T., George Giannoni, P.T. and Carol Gordon, P.T., and three expert witnesses, Kathleen Fincher, P.T., Joan Faulkner, P.T., and Guiseppina Feingold, M.D. The respondent also testified in her own defense, and Mr. Schooley was cross-examined by respondent. During the hearing, the respondent entered various exhibits, including patient #1's treatment records, a Guide for Physical Therapists Practice and a textbook written by the respondent and her husband, Dr. Giammatteo, D.C., P.T.

On January 7, 2010, respondent filed several motions, including a Motion to Dismiss, and Motions to Strike in conjunction with a post-hearing brief. On the same date, the Department filed a post-hearing brief. On January 29, 2010, the Department filed an Objection to respondent's Motions, and on February 8, 2010, respondent filed its Rebuttal to the Department's Post-Hearing Brief and Requested Oral Argument. The Board' denied the respondent's motions.

The hearings were held in accordance with the UAPA, Conn. Gen. Stat. § 4-166 et seq., and § 19a-9a-1 et seq. of the Regulations of Connecticut State Agencies. Each member of the Board involved in this decision attest that they have either heard the case or read the record before it in its entirety. This decision is based entirely on the evidentiary record established by the Board and the specialized professional knowledge of the Board in evaluating the evidence.⁶

⁶ The record before the Board consists of Department Exhibits 1 through 15, Respondent Exhibits A through Q, Board Exhibits 1 through 23, and the transcripts of the hearings from October 7, 2008 through November 3, 2009. The Board will cite to these exhibits and transcript in rendering this decision.

Allegations

1. In paragraph 1 of the Amended Charges, the Department alleges that respondent is and has been at all times referenced in the Charges, the holder of Connecticut license number 002852 to practice as a physical therapist.
2. In paragraph 2 of the Amended Charges, the Department alleges that at all times mentioned herein, respondent owned, operated, directed, maintained and/or controlled Desert Light Health Associates, LLC, and/or Center IMT, and/or Regional Physical Therapy Center (“RPT”) in Bloomfield, Connecticut.
3. In paragraph 3 of the Amended Charges, the Department alleges that from approximately November 1999 through January 2004, patient #1 was under the care of Regional Physical Therapy for treatment of a back injury. During this time, respondent, by and through her staff or herself:
 - a. Treated patient #1 excessively and unnecessarily;
 - b. Failed to utilize CPT codes and failed to provide line-item billing charges to the patient;
 - c. Examined and treated joints and other areas of the body that were not in the area of injury and without clinical justification;
 - d. Failed to maintain complete and adequate treatment records including, but not limited to, failure to fully document and record the patient’s treatment, progress and treatment plan;
 - e. Employed techniques, modalities, and treatments that do not meet the standard of care, are not an appropriate part of a treatment plan and are unapproved by any accepted physical therapy treatise or practice;
 - f. Improperly held herself out as being able to diagnose and treat medical conditions;
 - g. Recommended and provided therapy for psychological conditions outside the scope of practice for a physical therapist; and/or,
 - h. Failed to provide appropriate and adequate modalities required to treat the patient’s injuries.
4. In paragraph 4 of the Amended Charges, the Department alleges that the above-described facts constitute grounds for disciplinary action pursuant to §§ 20-73 of the Statutes, including, but not limited to, § 20-73a (2), (3), and (6).

Findings of Fact

1. Respondent is and has been at all times referenced in the Amended Charges, the holder of Connecticut license number 002852 to practice as a physical therapist. Bd. Exh. 18.
2. At all relevant times mentioned in the Amended Charges, the Respondent owned, operated, directed, maintained and/or controlled Regional Physical Therapy (RPT) and

Center IMT in Bloomfield, Connecticut. At all relevant times mentioned in the Amended Charges, patient # 1 received physical therapy at RPT and Center IMT (hereinafter "RPT"). Dept. Exh. 1, Tab 1, pp. 223-24, 226, 227, 232-34, 236, 238, 239, 240, 241, 246, 250, 253, 254-57, 260-62, 265, 267; Dept. Exh. 1, Tab 3, pp. 20, 21, 23, 25, 26, 27-32; Dept. Exh. 1, Tab 6, pp. 14-15; Dept. Exh. 1, Tab 7, pp. 13, 22, 23, 32, 47, 57-58, 60, 64, 69; Dept. Exh. 1, Tab 8, pp. 1-4; Dept. Exh. 1, Tab, 11, pp. 2, 4; Dept. Exh. 1, Tab 12, p. 49; Dept. Exh. 6; Dept. Exh. 8, pp. 95-96, 132; Tr. 11/4/08, p. 18; Tr. 11/18/08, pp. 12-14, 173; Tr. 3/3/09, pp. 7, 199-202, 207, Tr. 11/3/09, p. 42; Board Exh. 18; Resp. Exhs. D, E, F, and Q.

3. At all relevant times mentioned in the Amended Charges, Desert Light Health Associates (DLHA) was owned solely by Thomas Giammatteo, respondent's husband, and DLHA was a chiropractic practice. The evidence in the record is insufficient to establish that respondent owned, directed, maintained and/or controlled DLHA in Bloomfield, Connecticut. Dept. Exhs. 6, 8, pp. 125-26; Resp. Exh. Q; Tr. 10/21/08, pp. 47-48, 70-71; Tr. 11/4/08, p. 19; Tr. 3/3/09, pp. 20, 22, 35-36.
4. From approximately December 6, 1999 through January 27, 2004, patient #1 was a patient at RPT with a diagnosis of lower back pain sustained as a result of a dance/movement class in February of 1999. Dept. Exh. 1, Tab 3, p. 33; Dept. Exh. 1, Tab 6, pp. 14, 15; Bd. Exh. 18; Tr. 11/4/08, p. 86. Patient # 1 presented at RPT as a patient with chronic lower back pain based on the length of her injury. Tr. 2/3/09, pp. 26-27.
5. While a patient at RPT, the respondent and patient #1 had a patient-physical therapist relationship. Dept. Exh. 1, Tab 1, pp. 216; Dept. Exh. 1, Tab 3, p. 20, 28-31; Dept. Exh. 1, Tab 5, p. 5; Dept. Exh. 1, Tab 7, pp. 1-5, 8-13, 15-17, 23-28, 30-52, 55, 59-69, 71, 75-76, 79-83, 85-86, 88; Dept. Exh. 1, Tab 10; Dept. Exh. 1, Tab. 11, p. 2; Resp. Exhs. D, N; Tr. 10/21/08, pp. 86-89, 118-19; Tr. 11/4/08, pp. 55, 74, 156-57; Tr. 11/18/08, pp. 11-14, 30-31, 62, 109-10, 112, 121-22, 124-26, 137-39, 146-47; Tr. 2/3/09, pp. 145-46, 193-94; Tr. 3/3/09, pp. 96-97, 107 lines 9-12, 19-22, pp. 122-23, 129, 187; Tr. 6/2/09, pp. 38-41, 53, 76-77, 118-19; Tr. 11/3/09; pp. 105, 122-24, 131.
6. While a patient at RPT, patient #1 was treated approximately 395 times, often receiving multiple treatments per visit and several treatments per week by different physical therapists under the direction of and/or in consultation with the respondent. The respondent, by and through her staff or herself, treated patient #1 excessively and unnecessarily. Resp. Exhs. D, E, F.
7. While a patient at RPT, patient #1 received treatment for her lumbar, cervical and thoracic spine, pelvis, sacrum, neck, face/head/forehead, cranium, jaw, eyes, abdomen, ribs, sternum, kidneys, digestive track, ears, knees, ankles, lymph nodes, legs, hip, lungs, uterus, shoulder, tooth, elbow, adrenal glands, forearm, hands, mouth, maxilla, nose, bones, lymphatic drainage, "systems" and "total body." Patient #1 also received lymphatic drainage, deloading of the adrenal glands, mapping, neurofascial processing, decompression syndrome for the right thorax, imagery techniques, periosteal release of the eyes, myofascial release for the adrenal glands, joint mobilization of the ulna and

radius, NFP of the thyroid, MFR of the colon and GI tract, nutritional counseling, food supplements, vitamins and supplements. The respondent, by and through her staff or herself, treated joints and other areas of the body that were not in the area of injury and without clinical justification. The respondent, by and through her staff or herself, employed techniques, modalities and treatments that do not meet the standard of care. Dept. Exh. 1, Tab 1, pp. 9-16, 18-43, 51, 57-69, 72, 74, 87, 93-107, 114-29, 131-66, 168-89, 191-99, 201, 203-18, 220-24, 226-36, 238-53, 254-57, 260-67; Exh. 1, Tab 3, pp. 15, 18; Dept. Exh. 1, Tab 7, pp. 1, 3, 8-11, 13, 23, 25-28, 30, 33-34, 36-38, 60-61, 67-68, 71, 79; Dept. Exh. 7, pp. 54, 56-57, 61-71, 74-76, 77 lines 18-23; 79, 80, 102; Resp. Exhs. D, F, E; Tr. 11/4/08, pp. 99-101, 139, 140-47, 191-92, 194, 197-200, 208; Tr. 10/21/08, pp. 161-62.

8. While a patient at RPT, Patient #1 paid for all her physical therapy with private funds. Tr. 11/4/08, pp. 14, 127; Tr. 3/3/09, pp. 26-27, 55; Resp. Proposed Finding of Fact, ¶ 20.
9. While a patient at RPT, the respondent, by and through her staff or herself, did not utilize CPT codes or provide line-time billing charges to patient #1. Resp. Proposed Finding of Fact, ¶ 20; Dept. Exh. 1, Tab 12; Tr. 2/3/09, pp. 65-66, 91-92.
10. While a patient at RPT, patient # 1's treatment records did not contain documentation of: (1) adequate information sufficient to justify treatment rendered, (2) adequate assessments of range of motion before and/or after treatment; (3) objective measurable findings referenced back to the initial visit or assessments with revision of or restatement of goals after every five visits; (4) reevaluations every thirty to ninety days; or (5) detailed treatment or home exercise plans. The respondent, by and through her staff or herself, failed to maintain complete and adequate treatment records, including but not limited to, fully documenting and recording the patient's treatment, progress and treatment plans. Dept. Exh. 1, Tab 1, pp. 9-10, 12, 15, 22, 33, 72, 82, 94, 99, 102-03, 106, 114, 117-19, 121, 124, 127, 131, 133, 136, 141-42, 144, 154, 158, 160-62, 165-66, 168-69, 174, 176, 178-80, 182-83, 186-88, 191-93, 197-98, 201, 204, 209, 210, 227, 233-36, 239, 252, 254, 260; Dept. 7, pp. 51-57, 60-76, 94-100, 103; Dept. Exh., pp. 21-24, 32-36; Tr. 10/21/08, pp. 23-24, 118-19; Tr. 11/4/08, pp. 66-67, 236-37; Tr. 11/18/08, pp. 71-72, 75-78, 80-95, 100-01, 104, 128-35; Tr. 6/2/09, pp. 13-17; Resp. B.
11. The evidence is insufficient to establish that respondent, personally or by and through her staff, improperly held herself out as being able to diagnose and treat medical conditions. Dept. Exh. 1; Resp. Exhs. D, E, G, and K; Tr. 11/4/08, pp. 161-162; Tr. 11/18/08, pp. 50-53, 56-68, 108-111; Tr. 3/3/09, pp. 147, 150, 153-157, 163, 170-171, 182-184, 187-188; Tr. 6/2/09, pp. 7-11, 23-28, 71-72, 77-84, 110-113, 124-126.
12. The evidence is insufficient to establish that respondent, personally or by and through her staff, provided therapy for patient #1's psychological conditions outside the scope of practice for a physical therapist. The Respondent recommended that patient #1's obtain psychological counseling. Dept. Exh. 1; Resp. Exhs. D, E, G, and K; Tr. 10/21/08, pp. 121-124; Tr. 11/4/08, pp. 161-162, 230-231; Tr. 11/18/08, pp. 50-53, 56-59, 61-68, 108-111, 116-120, 126, 135, 138, 140-145, 168-174, 183-185, 195, 202, 206-207, 209; Tr.

3/3/09, pp. 147, 150, 153-157, 163, 170-171; Tr. 6/2/09, pp. 7-11, 23-28, 71-72, 77-84, 110-113, 126; Tr. 11/3/09, pp. 47-49.

13. The evidence is insufficient to establish that, respondent, personally or by and through her staff, failed to provide appropriate and adequate modalities required to treat the patient's injuries. Dept. Exh. 1; Resp. Exhs. D, E, G, and K; Dept. 8, pp. 51, 53, 85; Tr. 10/21/08, p. 168; Tr. 11/4/08, pp. 39, 141, 189, 205, 210; Tr. 11/18/08, pp. 11, 71, 72, 39, 95, 101-104, 119, 176-177.

Discussion and Conclusions of Law

The Department bears the burden of proof by a preponderance of the evidence. *Goldstar Medical Services, Inc., et al. v. Department of Social Services*, 288 Conn. 790 (2008); *Swiller v. Comm'r of Public Health*, CV-950705601, Superior Court, judicial district of Hartford-New Britain at Hartford, (October 10, 1995, *Hodgson, J.*); *Steadman v. SEC*, 450 U.S. 91, 101 S. Ct. 999, *reh'g den.*, 451 U.S. 933 (1981). The Department sustained its burden of proof with regard to the allegations contained in paragraph 1, all of the allegations in paragraph 2 except those pertaining to respondent's ownership and/or control of DLHA, and the allegations contained in paragraph 3, except those contained in subparagraphs (f), (g), and (h).

The Board relied upon the training and experience of its members in making its findings of facts and conclusions of law. *Pet v. Department of Health Services*, 228 Conn. 651, 667 (1994).

The Amended Charges allege that respondent's license is subject to disciplinary action pursuant to § 20-73a of the Statutes which provides, in pertinent part, that:

The Board of Examiners for Physical Therapists shall have jurisdiction to hear all charges of conduct that fails to conform to the accepted standards of practice of physical therapy brought against any person licensed as a physical therapist . . . and, after holding a hearing, . . . the board, if it finds such person to be guilty, may revoke or suspend such person's license or take any of the actions set forth in section 19a-17. . . . The causes for which such action may be taken are as follows: . . . (2) illegal, incompetent or negligent conduct in the practice of physical therapy . . . (3) aiding or abetting the unlawful practice of physical therapy; . . . (6) fraud or deception in obtaining a license. . . .

Respondent admits the allegations in paragraph 1 of the Amended Charges that, at all relevant times, she is and has been the holder of Connecticut license number 002852 to practice as a physical therapist.

With respect to paragraph 2 of the Amended Charges, the Board finds that the respondent owned, operated, directed, maintained and/or controlled Regional Physical Therapy (RPT) and

Center, IMT in Bloomfield, Connecticut. The Board further finds that at all relevant times referenced in the Amended Charges, patient # 1 received physical therapy services at RPT and Center IMT. At the hearing, Mr. Schooley testified that Center IMT, Inc. was a management company that purchased human resource services for RPT and various physical therapy companies under the branding name Center IMT and did not provide physical therapy services. (Dept. Exh. 8, pp. 105-07.) Mr. Schooley further testified that staff mistakenly generated treatment records with the Center IMT branding logo instead of the RPT logo. The Board does not find Mr. Schooley credible in this regard. Documentation in the record reflects patient #1 was treated at both RPT and Center IMT. See Dept. Exh. 1, Tab 1, pp. 232-34, 236, 238-41, 246, 250, 253-57, 260-62, 265, 267; Dept. Exh. 1, Tab 3, pp. 20-32; Dept. Exh. 1, Tab 5, pp. 37, 46, 48-49, 51-54, 56-57; Dept. Exh. 1, Tab 6, p. 14; Dept. Exh. 1, Tab 7, pp. 13, 22, 32, 47, 57, 60; Dept. Exh. 1, Tab 8, pp. 1-4; Dept. 1, Tab 11, pp. 2, 4.

With respect to the allegations in paragraph 2 of the Amended Charges that the respondent owned, directed, maintained and/or controlled DLHA, the Department failed to establish this allegation by a preponderance of the evidence. The evidence in the record establishes that DLHA is a chiropractic office owned and operated by Thomas Giammatteo, the respondent's husband. There was insufficient evidence to establish that the respondent directed, maintained, controlled or owned DLHA. Accordingly, based on the record established in this matter, the practice at DLHA is beyond the scope of this matter.

Thus, the Department sustained its burden of proof with regard to the allegations contained in paragraphs 1 and 2, except with respect to the allegations concerning DLHA.

Paragraph 3(a)-(h) of the Amended Charges alleges violations of the standard of care by the respondent, "by and through her staff and herself," stemming from patient #1's physical therapy at RPT. In her defense, respondent claims that she did not have a patient-physical therapist relationship with patient #1 since she did not provide "hands on" treatment to patient # 1 but instead acted as a "rehabilitation consultant" providing recommendations to the physical therapists treating patient #1 at RPT. The Board does not find the respondent credible in this regard.

In Connecticut, the practice of physical therapy specifically includes consultative services, which services the respondent undisputedly provided to the patient #1's treatment team while she was a patient at RPT. Conn. Gen. Stat. § 20-66. As also noted in the Guide to

Physical Therapist Practice, Respondent's Exhibit N, the scope of practice for physical therapists includes consultative services by a physical therapist to colleagues.

Additionally, Dr. Giuseppina Benincasa Feingold testified on behalf of the respondent regarding the role of a rehabilitation consultant in a multidisciplinary practice, such as the respondent's practice. Dr. Feingold testified that such consultative work is to be considered "treating the patient." Tr. 11/3/09, pp. 105, 119, 122, 130-31. Dr. Feingold testified that consultative work could only be performed under the scope of her healthcare license, and could not be performed absent such licensure. Tr. 11/3/09, p. 124. When performing such consultative services, Dr. Feingold further testified that she considered those individuals she was acting as a consultant for to be her patients as well. Tr. 11/3/09, pp. 105, 122, 127-131. Dr. Feingold testified that she would maintain separate charts for the patients she provided consultative services. Tr. 11/3/09, p. 127.

Furthermore, several of respondent's witnesses attested to respondent's direct involvement in patient #1's physical therapy at RPT. *See*, Dept. Exh. 1; Tr. 10/21/08, pp. 47, 51, 58, 70-71, 73-77, 87-88, 118-119, 121-122 Tr. 11/3/09, pp. 105, 122-124, 131; Tr. 11/18/08, pp. 13-14, 121-22. Ms. Carol Mills Gordon, respondent's partner and a physical therapist at RPT, testified that RPT was a multi-disciplinary practice developed by the respondent and herself involving a "team approach" that allowed patients to benefit from the expertise and special skills of various physical therapists. Tr. 11/18/2008, p. 12-13. Ms. Gordon testified that when she previously worked with the respondent at Mount Sinai Hospital, respondent was a rehabilitation consultant and "chief physical therapist" for the Hospital's physical therapy department.⁷ Tr. 11/18/08, p. 13. Ms. Gordon further testified that the respondent played a similar role during the course of patient # 1's treatment. *Id.*, pp. 13-14. As acknowledged by Ms. Gordon, the respondent was "clearly part of the team" with respect to patient #1's treatment. Tr. 11/18.08, p. 121; see also Dept. 1, Tab 3, p. 28 (letter from Ms. Gordon dated January 1, 2004 to patient # 1 stating that Ms. Gordon spoke with patient # 1's "team of therapists", including the respondent . . . that it was recommended that patient #1 continue with the respondent's "recommended

⁷ Respondent testified that as a rehabilitation consultant at Mount Sinai Hospital she "was involved in every aspect of all physical therapy, occupational therapy for sure, care, inpatient as well as outpatient." Tr. 3/3/09, p. 96. She further testified that she was responsible for program development including inpatient and outpatient chronic pain programs. *Id.* 96-97.

treatment plan of 11 hours of physical therapy per month,” and that respondent would provide two hours of physical therapy per month to patient # 1 free of charge.).

Mr. George Giannoni, a physical therapist at RPT, also credibly testified that there were many clinical discussions among RPT staff regarding patient # 1’s care and that many of those discussions were not documented in patient # 1’s treatment records. Tr. 11/21/08 pp. 118-21. Mr. Giannoni testified that such discussions were “absolutely” to be regarded as clinical care and plans of care, and that the respondent was personally involved in such clinical discussions regarding patient #1 “a lot of times.” Id., pp. 86-87, 118-19.

Furthermore, documentary evidence submitted by the Department establishes by a preponderance of the evidence that the respondent in her role as a “rehabilitation consultant” was actively involved and personally engaged in patient # 1’s treatment and treatment planning. The record is replete with years of email correspondence between respondent and patient #1 and/or correspondence among respondent, patient #1 and other practitioners who treated patient #1 reflecting her direct involvement with patient # 1’s treatment and treatment planning at RPT. Dept. Exh. 1, Tab 3, pp. 20, 21, 27- 31, Tab 7, pp. 2-5, 8-12, 15-17, 23-52, 55, 59-72, 74-83, 85-88. While not exhaustive, examples include the following: On December 2, 2001, patient # 1 writes to the respondent’s daughter, a physical therapist at RPT, that “I did the elimination NFP and shock NFP that your mom gave me a while ago.” Dept. Exh. 1, Tab 7, pp. 16-17. On December 22, 2002, the respondent writes to patient #1, “As President of the Company, I will not tolerate any longer insinuations, negative comments or any other lack of respect for the referral process. . . . We need you to gain weight. Period. Please inform me: how do you want to proceed. . . . I will see you the next time you are in CT.” Dept. Exh. 1, Tab 7, pp. 23-24. On May 5, 2003, patient # 1 writes to the respondent: “I am still motility testing. I haven’t stopped. Please tell me if I am not doing it correctly. . . . Thank you for the opportunity to be on your schedule!” Id., p. 25. On August 1, 2003, patient # 1 writes to the respondent, “I am doing anxiety systems again and processing the emotional body. These are helping somewhat, but not as much as they were helping last week, *after my session with you and Tammy.*” (Emphasis added.) Id., p. 28. The respondent replied to this email on August 2, 2003, as follows: “I strongly recommend that you continue to deload the adrenals. . . . Try to reach the adrenals and perform NFP to all PCs from the adrenals. . . . If you wish to get the adrenal systems performed by Kortney – probably 4 hours total – you can do so at N/C.” Id., pp. 28, 30. On May 1, 2003,

respondent writes to patient # 1 “Take it easy; some exercising within constraints, swimming is great. Walk with small strides for a few more weeks but don’t stop walking keep up the exercising.” Id., p. 31. On September 6, 2003, patient # 1 writes to the respondent “I wanted to let you know that I am ok, at home, and *thank you for the treatment yesterday* because I am beginning to experience some relief of some symptoms. . . .” (Emphasis added.) Id., p. 40. Respondent writes in an email dated September 7, 2003 to her colleagues: “I think it is evident that Carol, Joe and I will be [patient #1’s] team. No one else. ONLY IF I choose to put someone on a short-term project will this change.” Id., p. 45. On September 8, 2003, the respondent writes to staff “we should get her in. ONLY to me. For NC. For two hours.” Id., p. 49. On October 16, 2003, patient # 1 writes to the respondent: “Thank you for the homework guidance this week – it is indeed helping a lot, especially my back. . . .” Id., p. 59.

Additionally, patient # 1’s treatment record at RPT also reflects that patient # 1 was treated directly by the respondent. Dept. Exh. 1, Tab. 1, p. 216. Respondent also testified at the hearing that she provided “hands on” treatment to patient # 1 on at least two occasions.

Based on the forgoing, the Board finds that there was a patient-physical therapist relationship between the respondent and patient # 1, in which the respondent acted as patient # 1’s physical therapist, and directed RPT staff that provided care to patient # 1.

Paragraph 3(a) of the Amended Charges alleges that respondent, by and through her staff or herself, treated patient #1 excessively and unnecessarily. The Department sustained its burden of proof. On or about December 6, 2009, patient # 1 began treatment at RPT for a lower back injury as a result of a February 1999 injury during a dance/movement class. Dept. Exh. 1, Tab 3, pp. 4, 6, 33. Patient # 1 presented as a patient with chronic lower back pain based on the length of her injury. Patient #1 was a patient at RPT from December 6, 1999 until January 27, 2004, when she discontinued her physical therapy. During this period of time, patient # 1 received approximately 395 treatments at RPT, often receiving multiple treatments per day by different treating physical therapists and multiple treatments per week.

According to Dr. Zettergren, a patient with symptoms of lower back pain typically receives between eight to twenty four treatments. Dept. Exh. 7, Tr. 3/12/07, p. 82. In this case, patient # 1 presented to RPT as a patient with chronic, lower back pain and thus required treatment beyond the standard eight to twenty four visits an acute pain patient would normally require. Nevertheless, the Board finds based on its specialized professional knowledge that the

number of treatments patient # 1 received from 1999 through 2004 was excessive and unnecessary.

In reviewing patient # 1's treatment records, the Board finds that there were not minimal objective improvements in patient #1's functional status for her lower back injury that would support the number of physical therapy treatments patient #1 received at RPT. For example, patient #1's treatment records reflect that on December 6, 1999, the start of her treatment, her range of motion for lumbar flexion and extension was approximately 20° and 10°, respectively.⁸ On January 11, 2000, after approximately 55 treatments, her range of motion for lumbar flexion and extension was approximately 20° and 10°, respectively. On March 17, 2000, after approximately 100 treatments, patient #1's lumbar range of motion was approximately 20° for flexion and 5° for extension. On June 4, 2000, after approximately 150 treatments, patient #1's range of motion for lumbar flexion and extension was approximately 25° and 8°, respectively. On July 28, 2000, after approximately 200 treatments, her lumbar range of motion for flexion and extension was approximately 20° and 10°, respectively. On October 18, 2000, after approximately 250 treatments, patient #1's lumbar range of motion for flexion and extension was approximately 28° and 5°, respectively. On September 16, 2003, patient # 1's lumbar extension was approximately 20° after treatment; no flexion measurements were documented. Dr. Zettergren testified that patients, including chronic pain patients, should be discharged from physical therapy if they were no longer improving based on objective measurements. (Dept. 7, p. 144; Dept. 8, pp. 84-88.)

In a letter dated January 7, 2004 to Dr. Alexandra Houck, respondent and her staff acknowledge patient #1's minimal improvements in functional status. As stated by Ms. Gordon in the January 7, 2004 letter to Dr. Houck "there is apparently very minimal change in [patient # 1's] function." Ms. Gordon then inquires "Both Sharon and I would like to ask your recommendations about how to proceed with [patient #1's] physical therapy in view of her subjective improvements and strong desire to continue physical therapy, with minimal objective changes."

Thus, the Department sustained its burden of proof regarding this allegation.

⁸ Range of motion is an objective test used to measure patient progress in physical therapy. Dept. 7, pp. 52-53, 61, 95-96. For a patient with lower back pain, objective testing could include range of motion, manual muscle testing, standardized assessment tools for pain and function. *Id.*, p. 61, 96-97. In this case, the Board looked at patient #1's range of motion for her lumbar spine to measure objectively her progress since this is the measurement tool consistently documented in patient #1's treatment records. *Id.* 96.

The Department sustained its burden of proof with respect to the allegations in paragraph 3(b) that respondent, by and through her staff or herself, failed to utilize CPT codes and failed to provide line-item billing charges to the patient. Respondent admits the allegations, and Dr. Zettergren, Ms. Faulkner and Ms. Fincher each testified that CPT codes are treatment and diagnosis codes that identify services rendered and/or specific treatments patients receive. According to these witnesses, CPT codes are used primarily for reimbursement from third parties, such as insurance companies. In this case, however, patient #1 paid with private funds and was not seeking reimbursement from a third party insurer. Thus, there was no need to provide patient #1 with CPT codes; and, the standard of care does not require the provision of such codes for self-pay patients who are not seeking reimbursement. Thus, while the Department sustained its burden of proof with respect to these allegations, in this case, the Board finds that the respondent's conduct does not constitute a violation of the standard of care.

With respect to paragraph 3(c) of the Amended Charges, the Board finds that the Department sustained its burden of proof that the respondent, by and through her staff or herself, treated joints and other areas of the body that were not in the area of injury and without clinical justification. Patient # 1's presented to RPT for treatment for a back injury sustained during a dance movement class. During the course of her treatment at RPT, patient # 1's physical therapy included treatment of the following joints and body areas outside of her area of injury: jaw, eyes, abdomen, ribs, sternum, uterus, adrenal glands, lymph system, kidneys, ears, digestive tract, knees, nose, elbow, ankles, forearm, maxilla, lungs, hands, shoulder, tooth, bones, "systems" and "total body." The respondent maintains that treatment of these joints and areas was justified since these other body parts were affecting or contributing to patient #1's lower back pain.

The Board finds based on its specialized professional knowledge that treatment of these areas for patient #1, who presented with lower back pain, violated the standard of care. While lower back pain may be affected by other parts of the body, the standard of care requires that prior to treatment of these other areas, a physical therapist examine a patient, using objective tests or measures, to assess if treatment of these other areas is warranted. In this case, patient # 1's treatment records do not reflect that such objective measures and tests were performed on patient # 1 prior to treatment of the above identified areas. Rather it appears, based on patient # 1's treatment records, that physical therapy was performed on these areas based on patient # 1's

subjective complaints.⁹ Based on the lack of examination and assessment substantiating treatment, the Board finds that treatment of the above identified joints and areas for patient #1 was improper.

With respect to the allegations contained in paragraph 3(d) that respondent, by and through her staff or herself, failed to maintain complete and adequate treatment records including, but not limited to, fully documenting and recording the patient's treatment, progress and treatment plan, the Department sustained its burden of proof.

Section 19a-14-40 of the Regulations of Connecticut State Agencies (Regulations) provides: "The purpose of a medical record is to provide a vehicle for: documenting actions taken in patient management; documenting patient progress; providing meaningful medical information to other practitioners should the patient transfer to a new provider or should the provider be unavailable for some reason. A medical record shall include, but not be limited to, information sufficient to justify any diagnosis and treatment rendered." Section 19a-14-41 of the Regulations requires licensed physical therapists to "maintain appropriate medical records of assessment, diagnosis, and course of treatment provided to each patient."

The Physical Therapy Documentation Requirements by the Connecticut Physical Therapy Association (Physical Therapy Documentation Requirements) submitted into evidence by the respondent require physical therapists to document: (1) in treatment notes, a description of treatment received for each scheduled visit, and at least every five visits, objective measureable findings relating back to the initial evaluation and an assessment with revisions and/or restatement of goals and treatment plan based on progress toward goals; (2) in the plan of care, frequency, duration, treatment and goals; and, (3) revaluations of a patient every 30-90 days depending on frequency of treatment and acuity of symptoms, evidence of progress toward goals based on objective, functional, measurable changes, revised/restated goals, treatment plan to attain goals with justification for continuing, including frequency and duration, and evidence of communication with referring physician. Resp. Exh. N. Mr. Giannoni testified on behalf of the respondent that the Physical Therapy Documentation Requirements were in effect at the time patient # 1 received treatment at RPT and provided the minimum requirements for documentation for physical therapists in Connecticut. Tr. 10/21/08, pp. 19. The Board finds

⁹The prescriptions in patient #1's treatment records do not support treatment for the above identified areas at all or at the time treatment was rendered.

that these requirements and the requirements reflected in the above Regulation reflect the standard of care for record keeping for physical therapists.

The evidence in the record establishes that patient #1's treatment records at RPT do not comply with the standard of care reflected in Regulation or the Physical Therapy Documentation Requirements. Patient #1's treatment records do not document adequate information to justify treatment rendered on patient #1's jaw, tooth, nose, eyes, abdomen, adrenal glands, lymph nodes, kidneys, ears, digestive tract, knees, ankles, forearm, hands, bones, "systems" and "total body." As previously stated herein, patient #1's treatment records do not document any objective tests or measures used that may have warrant treatment of these areas. Patient #1's treatment records also do not contain explanation as to the type of joint mobilization performed. For example, there is no indication as to the grade or joint mode used. Dept. 7, p. 53, 56.

Patient #1's treatment records also do not consistently document range of motion for the area treated either before and/or after treatment, which would allow for a physical therapist to determine objectively patient progress or substantiate treatment performed. See e.g., Dept. Exh. 1, Tab 1, pp. 10, 12, 15, 22, 33, 72, 82, 94, 99, 102-03, 106, 114, 117-19, 121, 124, 127, 131, 133, 136, 141-42, 144, 154, 158, 160-62, 165-66, 168-69, 174, 176, 178-79, 180, 182-83, 186-88, 191-93, 197-98, 201, 204, 209-10, 227, 233-36, 239, 252, 254, 260. With the benefit of such objective measurement, a physical therapist is unable to measure objectively patient progress or substantiate treatment performed. Even Ms. Godiksen, who initially evaluated patient #1 in December of 1999, and was her physical therapist for more than a year, conceded that the numerous references to "improvements" in the treatment records actually refer to the improvements patient #1 experienced from the beginning of a particular treatment session until its end, but not from visit to visit.

Patient #1's treatment records also do not document after every five visits, objective measureable findings that were referenced back to the initial visit, or assessments with revision or restatement of goals. This failure violates the standard of care. The treatment records for patient #1 also lack documentation that patient #1 was reevaluated every thirty to ninety days to measure objectively the effectiveness and outcome of treatment. This failure also violates the standard of care.

Furthermore, the documented treatment plans and the home exercise plans contained in patient #1's treatment records violate the standard of care. The treatment plan does not comply

with standard of care which requires documentation of goals, treatment, frequency and duration. Rather, most of her treatment records have only check marks next to the words exercise, mobilization, manual therapy, movement therapy, or functional therapy/ADL.

Likewise, patient # 1's treatment records fail to document properly patient # 1's home exercise program. Dr. Zettergren testified, if a home exercise program is prescribed a copy of such program should be placed in the patient's treatment record detailing the exercises to be performed and should be signed and dated by the physical therapist. Dr. Zettergren testified that it must also include instructions as to frequency, intensity and duration. Such specificity is lacking in patient #1's treatment records. Patient #1's treatment records do not comport with these requirements. Rather, many of patient # 1's treatment records state that the home exercise program is "NFP."

Paragraph 3(e) of the Amended Charges alleges that respondent, by and through her staff or herself, employed techniques, modalities, and treatments that do not meet the standard of care, are not an appropriate part of a treatment plan, and are unapproved by any accepted physical therapy treatise or practice. The Board finds that the Department sustained its burden of proof in that the respondent, by and through her staff or herself, employed techniques, modalities and treatments that do not meet the standard of care. The standard of care requires that a patient with lower back pain should be evaluated with objective testing and measures, which would include, among other things, range of motion, manual muscle testing, and standardized assessment tools for pain and function. Dr. Zettergren's testified that reasonable, appropriate and approved physical therapy treatment for such a patient could include manual therapy; joint mobilization; possible treatment for referred pain down the back of the leg; exercise; detailed instructions in how to avoid situations which could inflict more pain to the lower back; instructions in energy conservation techniques to help relieve the pain in the lower back; hot packs; and, ultrasound and electrical stimulation. The Board finds based on its specialized professional knowledge that reasonable and acceptable treatments, modalities or techniques would *not* include deloading of the adrenal glands; neurofascial process ("NFP"); hand mapping; decompression syndrome of the right lateral thorax; imagery techniques; periosteal release of the eyes; myofascial release ("MFR") for the adrenal glands; joint mobilization of the ulna and radius (areas of the lower forearm); and, NFP of the thyroid or MFR of the colon and G.I. tract; --all techniques and

modalities which were used to treat patient #1. To engage in such techniques, modalities and treatments in the treatment of patient #1 violates the standard of care.

It is also a violation of the standard of care to provide nutritional advice or counseling to physical therapy patients. Despite respondent's admission that physical therapists are not permitted within the scope of their practice to provide nutritional advice or counseling, there are numerous documents in the record establishing that respondent and/or her staff offered nutritional advice or counseling, supplements or food supplements to patient #1 concerning her weight, gastrointestinal issues, and chronic constipation.¹⁰

Under cross examination, respondent was asked to explain why she offered patient #1 nutritional counseling or advice, and she responded that all nutritional counseling was under the supervision of her husband, a chiropractor, and not under her license as a physical therapist. Respondent claims that emails concerning nutritional matters were actually written in consultation with and on behalf of her husband, Dr. Giammatteo. The Board does not find respondent's explanations credible. Several of the emails regarding nutritional counsel are directly to the respondent from patient #1 or from the respondent to patient #1 or respondent's staff with only respondent's signature on the bottom of the email. Dept. Exh. 1, Tab 7, pp. 3-5, 8, 9, 10, 11, 33, 36-38, 60-61. Thus, the Board finds that the Department sustained its burden of proof that respondent, by and through her staff or herself, employed techniques, modalities, and treatments that do not meet the standard of care.

With respect to the allegations contained in paragraph 3(f) that respondent improperly held herself out as being able to diagnose and treat medical conditions, the Department did not sustain its burden of proof. The Board finds that there is insufficient evidence to establish that respondent improperly represented that she was qualified to diagnose and treat medical conditions. The Department's evidence was successfully rebutted by sufficient evidence that on numerous occasions respondent and/or her staff members recommended to patient #1 that she

¹⁰ See, e.g., Dept. Exh. 1, tab 7, p. 3 (“[b]ecause your issues appear to be requirements for vitamins, minerals/supplements (VMS) and functional medicine as well as dietary. . .); p. 8 (“IS she eating? Enough? By now she should be up to a 50% regular diet with FM [functional medicine] restrictions. Frequent food high in caloric count.”); p. 9 (“Nice job in the food testing. . . Find a place, which makes HUMUS[sic] and TEHINA[sic]. Test that. It would be a GREAT source of protein.”); (“the problem is that you are not gaining weight. You are the subject of ongoing consultations. You have the opportunity to gain 10 lbs during the ne[xt] 3 months. If you do not/cannot gain that weight, we will determine that our intervention (IMT with IDAP) is not successful”); p. 37 (“Seems like the UltraClear helped to start a vital detox process for you. You quite obviously, to all of us, have a lot of toxicity and perhaps you don’t realize: because you have the chronic constipation, you need to detox through other means . . .”).

seek medical treatment for her gastrointestinal problems and other medical conditions. In many instances, respondent consistently and strongly encouraged patient #1 to consult with a physician about her “elimination problems.” In an email dated June 6, 2003, respondent wrote to patient #1: “[A]nd [w]hen you get concerned: please focus on getting an MD check up.” *See also*, correspondence and emails, dated September 1, October 3, October 28, and December 1, 2003.¹¹

The Department’s expert witness, Dr. Zettergren, concurred with respondent’s recommendations to patient #1. In her testimony, Dr. Zettergren clearly stated that the standard of care would require a physical therapist to refer a patient who presented with GI symptoms to a physician. Thus, the evidence is insufficient to establish this allegation.

With respect to the allegations in paragraph 3(g) that respondent practiced outside the scope of her license by recommending therapy for patient #1’s psychological conditions, the evidence is sufficient to establish that respondent recommended therapy for patient #1, but it is not a violation of the standard of care to make such a recommendation. Therefore, this finding is not a sufficient basis to impose discipline on respondent’s license.

With respect to the allegation in paragraph 3(g) that respondent practiced outside the scope of her license by providing therapy for patient #1’s psychological conditions, the evidence is insufficient to support this claim. The record establishes that after respondent recognized patient #1’s psychological issues, she attempted to refer patient #1 to appropriate care and, in several instances, was adamant that patient #1 consult with a psychotherapist. Specifically, in an email dated May 10, 2003, respondent wrote to patient#1 that: “Once again, I would recommend a therapist, non aggressive and non invasive, to help you with the psychoemotional therapeutic

¹¹ *See, e.g.*, Dept. Exh. 1, tab 7, p. 34 (“ Once again, I believe you require a great MD, a gastroenterologist or someone advanced in the field of gastroenterology. . . . I would say, once again: you should see a doctor, an MD who can do tests and try to get to the bottom of this. . . . We do not want to ‘make you’ go to a doctor. We want to help you and support your choices. Yet there is no doubt that you require more than what we are offering Please: consider one more time, visiting an MD who has expertise in the GI tract.”); p. 57 (“I was very pleased to speak with Dr. Hoack [sic] and expressed our concerns for [patient#1’s] psychological and physical well-being. I stated that we had told [patient #1] that we were not comfortable continuing with physical therapy under a chiropractor’s referral when there are other medical and psychological issues apparent. . . . Dr. Hoack [sic] had strongly recommended bloodwork for [patient #1], which [patient #1] had not gone for at the time of our conversation today. I told Dr. Hoack [sic] that I would reinforce our position of patient#1’s need to be followed closely by her physician and psychotherapist while she undergoes physical therapy”); p. 64 (“We, your Team at RPT, understand that you are concerned about blood tests. [W]e heard, . . . that you feel we stated you should not get blood tests. That is absolutely not correct. . . . For years we have been trying to get more tests and measurements performed, for more accurate diagnostics. We are please [sic] that your MD is interested in doing such tests, in order to give you support. . . . We support 100% the process of medical diagnostics and interventions, together with psychotherapeutic support.”); and, p. 79 (“ . . . We know we are not equipped to manage as primary case managers your elimination problems.”)

intervention of eating disorders. . . . You should consider eating disorder specialist in the field of psychotherapeutics.” *See also*, memoranda and correspondence dated September 1 and 7, 2003.¹²

Eventually, respondent sought and paid for consultation for patient #1 with Dr. Karen Drucker, a psychologist in their network. *See*, Dept. Exh. 1, tab 13, p. 3.¹³ *See also*, Dept. Exh. 1, tab 3 at p. 27.

With respect to the allegations contained in paragraph 3(h) that respondent failed to provide appropriate and adequate modalities required to treat the patient’s injuries, the Department did not sustain its burden of proof. While the Board finds that some of respondent’s techniques, modalities, and treatments as previously discussed do not meet the standard of care, respondent also used other techniques and modalities that were appropriate and adequate to treat the patient’s injuries. Specifically, the Board finds that respondent used self-management techniques and manual therapy, all which are within the standard of care. Therefore, the Board finds that the Department did not sustain its burden of proof with respect to these allegations.

Based on the foregoing, the respondent’s license is subject to discipline pursuant to § 20-73a(2) of the Statutes, for the allegations contained in paragraphs 3(a), 3(c), 3(d), and 3(e) of the Amended Charges that were proven by a preponderance of the evidence. With respect to the allegations that respondent aided or abetted the unlawful practice of physical therapy or committed fraud or deception in obtaining a license, in violation of §§ 20-73a (3) and (6) of the Statutes, respectively, the Board finds that the Department failed to sustain its burden of proof since none of the foregoing proven allegations constitutes a violation of these provisions. With

¹²*See, e.g.*, Dept. Exh. 1, tab 7, p. 33 (“Deborah [Foreman, patient #1’s social worker] did express concern for [patient#1’s] psychological and medical well-being, with which I concurred. I stated emphatically that we have instructed [patient #1] that she is required to be followed with psychological and medical support in order to continue physical therapy. Deborah thought this was an appropriate suggestion.”); and, p. 34 (“1. Once again, I beleive [sic] you need to start as soon as possible, and continue with a psychologist/psychotherapist who will give you the support you require. Perhaps a % of the elimination problems is psychological. Perhaps more is physical. There is no doubt that when some of your stress is reduced, the smooth muscle spasm of the colon is reduced, and you function somewhat better.”)

¹³*See, e.g.*, Dept. Exh. 1, tab 7, p. 39 (“Please start with a Psychologist in the Boston area. I realize that you need to find funds if you are not insured. Perhaps you can find someone through the school . . . Since you began [physical] therapy, in such severe pain and disability, I have always concurred with you that you had severe physical problems. They are much improved. I always requested, tried to persuade, cajole, etc., that you go to someone from the field of psychology. You refused and indeed you have been compliant: trying to do self-healing at home. It is just not enough. You may not require a lot of psychotherapy, but you do require some. I know you enjoyed your session with Dr. Karen Drucker in August. I need her input and I hope that you will give me approval. Then we can sort out how best to help you.”)

respect to the allegations that the respondent violated § 20-73, the Board finds that the Department did not sustain its burden of proof since the respondent had the required prescriptions to treat patient # 1.

Based on the seriousness of the violations found in this matter, the Board finds that the respondent cannot practice with reasonable skill and safety without the imposition of the terms and conditions of probation detailed in the Order set forth below. In making the determination of the appropriate level and scope of discipline to be imposed, the Board is mindful that the respondent previously entered into a consent order with the Department stemming from respondent's failure to properly care for a patient and insufficient records by the respondent and her staff, in which the respondent was placed on probation for a period of eighteen months. The terms and conditions of probation under the consent order required the respondent to take continuing education classes, focused on documentation, treatment planning and treatment methods, and to have monitoring of her patient records.

Order

Based upon the record in this case, the above findings of fact and conclusions of law, and pursuant to §§ 19a-17 and 20-73a of the Statutes, the Board hereby orders the following with regard to Connecticut license number 002852, held by Sharon Weiselfish-Giammatteo, P.T., Petition number 2005-0104-014-001.

1. For purposes of this Order, the term "practice setting" shall mean any location where the respondent provides physical therapy, including consultative services to patients or health care practitioners providing physical therapy, or directs or supervises health care practitioners providing physical therapy.
2. For the violations found by the Board in paragraphs 3(a), 3(c), 3(d), and 3(e) of the Amended Charges, the respondent shall pay a civil penalty of \$10,000 by certified or cashier's check payable to "Treasurer, State of Connecticut." The check shall reference the Petition Number on the face of the check, and shall be payable within thirty days of the effective date of this Decision.
3. For the violations found by the Board in paragraphs 3(a), 3(c), 3(d), and 3(e) of the Amended Charges, the respondent's license number 002852 is hereby placed on probation for a period of two (2) years in accordance with the terms and conditions set forth below.

4. The Board finds the violations set forth in paragraphs 3(a), 3(c), 3(d), and 3(e) of the Amended Charges are severable and each separate violation warrants probation of the respondent's license and imposition of the civil penalty.
5. For the violations in paragraphs 3(a), 3(c), 3(d) and 3(e), the respondent shall comply with the following terms and conditions during probation.
 - a. Within the first year of the probationary period, respondent shall attend and successfully complete a course in professional ethics, pre-approved by the Department. Within 30 days of the completion of such coursework, respondent shall provide the Department with proof, to the Department's satisfaction, of the successful completion of such course.
 - b. Within the first six months of the probationary period, respondent shall attend and successfully complete 24 hours of continuing education, focused on documentation, treatment planning and treatment methods, pre-approved by the Department. Within 30 days of the completion of such coursework, respondent shall provide the Department with proof, to the Department's satisfaction, of the successful completion of such course.
6. For the violations in paragraphs 3(a), 3(c), and 3(e), starting within 3 months of the start of probation and until probation period is completed, the respondent may not work in any practice setting unless the following terms and conditions are met.
 - a. The practice setting must have in place the services of an expert in physical therapy quality assurance and quality assurance monitoring ("the QA expert") to develop and implement a comprehensive quality assurance program ("the QA program"). The QA program shall be applicable to the respondent's practice and the practice setting. The QA expert shall be pre-approved by the Department. The respondent shall bear at her own expense the costs of the QA expert if the practice setting does not do so.

The QA program shall incorporate and apply standards and policies including but not limited to patient assessment; patient outcomes; patient satisfaction; duration and appropriateness of treatment, including descriptions of reasonable evidence-based treatments and modalities for each physical therapy diagnosis commonly treated at the practice setting; discharge; and, follow-up care after discharge. The QA expert shall have the right to monitor the respondent's practice and the practice setting by any reasonable means, which he or she deems appropriate. The QA expert shall also have access to patient treatment records, patient practice protocols, office operating procedures, quality metrics, billing records, and other reasonable documentation necessary to establish the QA program. Respondent shall fully cooperate and shall ensure that staff at the practice setting fully cooperates with the QA expert in developing and implementing the QA Program.

- b. The QA expert shall conduct quarterly a random review of at least twenty (20%) percent of or twenty (20) patient records at the respondent's practice and the practice

setting, whichever is the larger number, created or updated during the probationary period, to insure compliance with the QA Program. In the event, the respondent's practice or the practice setting has less than (20) patients, the QA expert shall review all of patient records at the respondent's practice or the practice setting.

The QA expert shall meet with the respondent not less than once every quarter for the entire probationary period. The QA expert shall have the right to monitor the respondent's practice and the practice setting by any other reasonable means which he or she deems appropriate. Respondent shall fully cooperate with the QA expert in providing such monitoring.

Respondent shall be responsible for assuring that the QA expert files written monitor reports directly to the Department every three months of the probationary period. Such reports shall include documentation of dates and durations of meetings with respondent, number and a general description of the patient records, additional monitoring techniques utilized, and statement that respondent is practicing with reasonable skill and safety.

7. For the violation set forth in paragraphs 3(d) of the Amended Charges, starting within 3 months of the start of probation and until probation period is completed, the respondent may not work in any practice setting unless the following terms and conditions are met.

a. The practice setting must have in place the services of an expert in physical therapy documentation (Documentation Expert), pre-approved by the Department, to determine whether appropriate policies and procedures governing documentation standards applicable to the respondent's practice and the practice setting are being utilized and if not to develop such policies and procedures. The practice setting shall adopt any such policies or procedures as recommended by the Documentation Expert. If qualified and pre-approved by the Department, the QA expert may also serve as the Documentation Expert. The Documentation Expert shall have the right to monitor the respondent's practice and the practice setting by any reasonable means, which he or she deems appropriate. The Document Expert shall also have access patient treatment records, patient practice protocols, office operating procedures, quality metrics, billing records, and any reasonable documentation necessary to oversee development and compliance with documentation policies and procedures. Respondent shall fully cooperate and shall ensure staff at the practice setting cooperates with the Document Expert in performing the duties set forth herein. The respondent shall bear at her own expense the costs of the Document Expert if the practice setting does not do so.

b. Within the first month after the Documentation Expert has determined that appropriate documentation standards have been established, Documentation Expert shall initiate a quarterly random review of at least at least twenty (20%) percent of or twenty (20) patient records at respondent's practice and the practice setting, whichever is the larger number, created or updated during the probationary term, whichever is the larger

number, to insure compliance with the documentation policies and procedures developed in paragraph 7(a) above. In the event respondent's practice or the practice setting has 20 or fewer patients, the monitor shall review all of the patient records at the respondent's practice or the practice setting.

The Documentation Expert shall meet with the respondent not less than once every quarter for the entire probationary period. The Documentation Expert shall have the right to monitor respondent's practice or the practice setting by any other reasonable means, which he or she deems appropriate. The respondent shall fully cooperate and shall ensure that the practice setting fully cooperates with the Documentation Expert in providing such monitoring.

Respondent shall be responsible for assuring that the Document Expert provides written reports directly to the Department every three months of the probationary period. Such reports shall include documentation of dates and durations of meetings with respondent, number and a general description of the patient records, additional monitoring techniques utilized, and statement that respondent is practicing with reasonable skill and safety.

8. All correspondence and reports are to be addressed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

Ms. Pinkerton may also be contacted at the following email address:
bonnie.pinkerton@ct.gov.

9. Respondent shall pay all costs necessary to comply with this Decision.
10. In the event respondent is not employed as a physical therapist for periods of 30 consecutive days or longer, or is employed as a physical therapist for less than 20 hours per week, or is employed outside of the State of Connecticut, respondent shall notify the Department in writing. Such periods of time shall not be counted in reducing the probationary period covered by this Decision.
11. Legal notice shall be sufficient if sent to respondent's last known address of record reported to the Office of Practitioner Licensing and Certification of the Healthcare Systems Branch of the Department.
12. This document has no bearing on any criminal liability without the written consent of the Director of the Medicaid Fraud Control Unit or the Bureau Chief of the Division of Criminal Justice's Statewide Prosecution Bureau.

This Order is effective as of the date of signature.

Connecticut State Board of Examiners for Physical Therapists

6/13/11
Date

Sandra Worrell
By: Sandra Worrell, Chairperson

CERTIFICATION

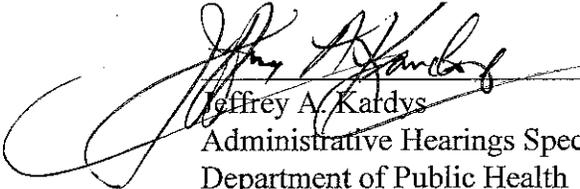
I hereby certify that, pursuant to Connecticut General Statutes § 4-180(c), a copy of the foregoing Memorandum of Decision was sent this 13th day of June 2011, by certified mail, return receipt requested to:

Michael Kogut, Esq.
O'Connell, Plumb & Mackinnon, P.C
75 Market Place
Springfield, MA 01103

Certified Mail 7004-1160-0000-8837-0098

and via email to:

Matthew Antonetti, Principal Attorney
Legal Office
Department of Public Health
410 Capitol Avenue, MS #12LEG
Hartford, CT 06134-0308


Jeffrey A. Kardys
Administrative Hearings Specialist/Board Liaison
Department of Public Health
Public Health Hearing Office