IN THE MATTER OF	*	**BEFORE THE BOARD**
JAMES R. CLARKE, P.T.	*	**OF PHYSICAL THERAPY**
Respondent	*	**EXAMINERS**
License Number: 15975	*	

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CONSENT ORDER

PROCEDURAL BACKGROUND

On May 21, 2002, the State Board of Physical Therapy Examiners (the "Board") charged James R. Clarke, P.T. (the "Respondent") (D.O.B. 10/30/61), License Number 15975, under the Maryland Physical Therapy Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 13-101 et seq. (2000).

Specifically, the Board charged the Respondent with violating the following provisions of H.O. § 13-316:

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee or holder:
>
> (2) Fraudulently or deceptively uses a license, temporary license, or restricted license;
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> (9) To an extent that impairs professional competence, habitually uses any : (i) drug;
>
> (13) Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy;
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> (15) Submits a false statement to collect a fee;
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> (16) Violating any provision of this title or rule or regulation adopted by the Board;

(20) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy;

(21) Grossly overutilizes health care services;

(24) Provides professional services while: (ii) using any narcotic or controlled dangerous substance, as defined in Article 27 of the Code, or other drug that is in excess of therapeutic amounts or without valid medical indication;

(26) Fails to meet accepted standards in delivering physical therapy or limited physical therapy care.

The Board also charged the Respondent with violating Code Md. Regs. ("COMAR") tit. 10, § 38.03.02 (2000), Standards of Practice:

COMAR 10.38.03.02 Standards.

A. The physical therapist shall exercise sound professional judgment in the use of evaluation and treatment procedures.

Q. The physical therapist shall work within the physical therapist competency in physical therapy evaluation and treatment.

COMAR 10.38.03.02-1 Requirements for Documentation.

A. As established by the American Physical Therapy Association of Maryland, and as approved by the Board, the physical therapist shall document the patient's chart as follows:

(1) For initial visit:
(a) Date,
(b) Condition/diagnosis for which physical therapy is being rendered,
(c) Onset,
(d) History, if not previously recorded,
(e) Evaluation and results of tests (measurable and objective data),
(f) Interpretation,
(g) Goals
(h) Plan of care, and
(i) Signature, title (PT), and license number;

(2) For subsequent visits:
(a) Date,

(b) Modalities, procedures, etc.,
(c) Cancellations, no-shows,
(d) Response to treatment,
(e) Signature and title (PT), with identifying signatures appearing on the patient's chart, although the flow chart may by initialed,
(f) Weekly progress or lack of it,
(g) Unusual incident/unusual response,
(h) Change in plan of care,
(i) Temporary discontinuation or interruption of services and reasons,
(j) Reevaluation, and
(k) If there is a physical therapist assistant, reevaluate and document as required by Regulation .02L of this chapter;

(3) For discharge or last visit:
(a) Date,
(b) Reason for discharge,
(c) Status at discharge,
(d) Recommendations for follow-up and
(e) Signature and title.

On August 13, 2002, a conference with regard to this matter was held before the Case Resolution Conference (the "CRC"). As a result of negotiations entered into before the CRC, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order. This Consent Order was approved by the Board on August 20, 2002.

FINDINGS OF FACT

BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice physical therapy in the State of Maryland. The Respondent was initially licensed to practice physical therapy in Maryland in 1986 under License Number 15975.

2. At all times relevant, the Respondent maintained offices for the practice of physical therapy at the following addresses: 2730 University Boulevard, W. Suite 802, Wheaton, Maryland 20902; 50 W. Edmonston Drive, Suite 601, Rockville, Maryland 20852; and 15200 Shady Grove Road, Suite 300, Gaithersburg, Maryland 20877.

3. On or about August 9, 1997, the Respondent was injured in a motor vehicle accident in a shopping center parking lot when an automobile backed into a utility trailer that was hitched to the back of the Respondent's van. At the time of the collision, the Respondent was positioned in the rear of the van where he was loading packages. The Respondent reportedly was ejected from the rear of the van, causing him to fall and injure himself.

4. Directly after the accident, the Respondent did not seek medical care from another health care professional but instead, treated himself with various physical therapy modalities. Sometime after sustaining his injuries, the Respondent consulted with and sought medical care from Dr. David Higgins, an area-orthopedist with whom the Respondent had a major professional referral relationship. Dr. Higgins initially treated the Respondent for low back and leg pain throughout the remainder of 1997. In December 1997, the Respondent underwent left knee surgery, performed by Dr. Higgins.

5. After this surgery, the Respondent continued to be followed by Dr. Higgins for various forms of low back and leg pain. The Respondent also underwent medical evaluation and treatment by a number of other physicians, including orthopedists, radiologists, physiatrists and psychiatrists, as well as

other health care providers, including chiropractors, acupuncturists, physical therapists and occupational health specialists. After his initial accident and while under medical treatment, the Respondent underwent periodic radiographic studies to assess his lumbosacral status. The Respondent's radiographic testing did not indicate significant evidence of disc herniation or impingement.

6. In September 1998, the Respondent sustained an injury to his right shoulder which he attributed to leg weakness occurring as a result of his automobile accident injury. The Respondent then underwent right shoulder arthroscopy performed by Dr. Higgins in January, 1999. After his surgery, Dr. Higgins referred the Respondent to another orthopedic surgeon, Dr. Jeffrey Kozak, who at the time practiced in the Houston, Texas area. Dr. Higgins accompanied the Respondent to his evaluation with Dr. Kozak in Texas.

7. After the shoulder surgery, the Respondent also underwent physical therapy treatments administered by Michelle L. Blount, a physical therapist employed in his office. The Respondent's last physical therapy appointment was noted in his billing records as being on March 1, 2000.

8. At some point after sustaining the injuries referred to above, the Respondent pursued a civil action against the individual who caused the 1997 motor vehicle accident. During the course of this litigation, the Respondent produced a series of documents he formulated relating to this matter. Among these documents were a series of physical therapy reports he wrote which chronicled his condition and the physical therapy treatments he provided to himself; and a billing statement which documented the treatments he self-

provided, the dates such treatments were provided, and the costs of such treatments.

9. On or about April 14, 2000, the Board received a report from a physical therapist who had been retained for litigation purposes to examine the various medical, billing and physical therapy records pertaining to the Respondent's 1997 motor vehicle accident. The reviewer also reviewed other documents compiled with respect to this matter, including the typed memoranda written by the Respondent referred to above.

10. In his report, the reviewer questioned the extent of the Respondent's injuries and the extent to which they were causally related to the 1997 automobile accident. In addition, the reviewer questioned the legitimacy of the Respondent's representations contained in his reports, in which the Respondent stated that he performed initial and follow-up physical self-examinations and self-administered extensive physical therapy treatments. The reviewer also questioned the Respondent's ability to make accurate and objective assessments of his condition, and the extent to which the physical therapy treatments administered were reasonable and necessary in view of the injuries he sustained.

11. Based on this report, the Board initiated an investigation of this matter. Pursuant to its investigation, the Board acquired various materials associated with this matter, including but not limited to the medical records compiled by the physicians who evaluated and treated the Respondent; the

Respondent's typewritten reports and billing records; and statements made by the Respondent and members of his staff.

12. After compiling this information, the Board, on or about October 4, 2000, referred this matter to a licensed physical therapist for a review of the Respondent's actions. Thereafter, the peer reviewer conducted a review of this matter. Among the documents examined by the reviewer were the reports written by the Respondent referred to above. The Respondent compiled approximately 30 typewritten reports dating from August 9, 1997 until June 12, 1998. All of the reports were on the Respondent's professional letterhead, were titled "Office Note," and were structured to resemble documentation written by physical therapists. These reports were one-to-three pages in length and identify the subject of the Office Notes as "James R. Clarke." Most of the reports were segmented into various subheadings, such as "Physical Findings," "Treatment," and "Plan." Each Office Note was signed "Best regards, James R. Clarke, P.T." Throughout the narrative of each Office Note, the Respondent typically referred to himself in the third person (e.g., "Mr. Clarke" or "the patient"), notwithstanding the fact that he was making reference to himself. The Respondent's Office Notes characterize the Respondent as a physical therapy patient who came in for scheduled evaluations and treatments (e.g., Office Note for October 28, 1997: "Mr. Clarke presents today for a scheduled appointment.")

13. The reviewer also examined the billing statement referred to above, titled "Statement of Professional Services" (hereinafter "the Statement"). The Statement is printed on the Respondent's letterhead, and lists specific physical

therapy services provided by the Respondent to "James R. Clarke," whom the Respondent identified as the patient and recipient of such services. The Statement lists the Respondent's referring physician as "David Higgins, M.D.," and the Respondent's diagnoses as lumbosacral strain, knee pain and ankle pain. The Statement records the dates the Respondent provided such services, the specific services provided, their costs, and Current Procedure Terminology ("CPT") and diagnostic coding information.

14. The Statement records that from August 11, 1997 to September 30, 1998, the Respondent provided/received approximately 161 physical therapy treatments. The Respondent listed billings for physical therapy services initially on a daily basis, followed by continued physical therapy on a two-to-three times per week basis during the period of treatment. For the period of August 11, 1997 through October 20, 1997, the Respondent recorded that he self-administered 43 physical therapy treatments, consisting of the application of a hydrocollator pack, electrical stimulation, ultrasound, and massage. Between October 24, 1997 and December 15, 1997, the Respondent documented self-administering 25 additional treatments consisting of the same multiple passive modalities, as well as therapeutic exercise. The Respondent reported receiving such multiple passive modalities until March 17, 1999.

II. SUMMARY OF FINDINGS

15. The Respondent violated the Act and the COMAR regulations with respect to his actions following his 1997 motor vehicle accident. After becoming injured in this accident, the Respondent evaluated himself to determine the

extent of his injuries, and documented his findings in a series of reports or "Office Notes" designed to resemble physical therapy records which were used by him as a diary upon advice of his counsel. The Respondent assessed himself through the use of certain testing procedures which cannot accurately and objectively be performed on oneself; rather, in order to be reliable, such testing requires the assistance of an independent examiner.

16. After assessing himself in this manner, the Respondent self-administered multiple forms of physical therapy treatments which either cannot be self-administered or which would be extremely difficult to administer in a competent manner, particularly in view of the Respondent's physical condition at the time. Under the circumstances, several of the treatments the Respondent documented require the assistance of or administration by an independent physical therapist.

17. Throughout the course of the Respondent's self-administration of physical therapy treatments, the Respondent was prescribed various forms of narcotic analgesic pain medications which have the potential to produce dependency or habituation in the user. While taking such medications, the Respondent reportedly became habituated to them, and continued to engage in the practice of physical therapy upon himself.

18. There are numerous discrepancies between the various forms of documentation the Respondent maintained with respect to this matter. There are several instances where there are contradictions between what the Respondent represented in his Office Notes versus those he made in his Statement. Further,

the Respondent failed to adhere to the requirements for documentation as established by the American Physical Therapy Association of Maryland and as approved by the Board, as set forth under COMAR 10.38.03.02.1.

19. In addition, the Respondent's assertions in his Office Notes regarding his assessment of his own injuries and the treatment modalities he self-administered are not objective or credible, in view of the testing procedures he purportedly used in his self-evaluation and subsequent reevaluations. Because of this, the Respondent's determination of the medical necessity for the physical therapy treatments was not objective, in that these assessments were not determined by an objective, third party. Support for the high utilization was not substantiated by objective findings.

20. Examples of the above are set forth infra.

III. SPECIFIC FINDINGS

21. There are numerous contradictions between the representations the Respondent made in his Office Notes and those he documented in the Statement. For example, in his Office Note, the Respondent documented that he performed his first self-evaluation on August 9, 1997. In contrast, however, the Respondent documented in his Statement that his first evaluation occurred on August 11, 1997. Thereafter, there are additional contradictions between the representations the Respondent recorded in his Office Notes and those he documented in the Statement. For example, in a number of instances, the Respondent represented in his Statement that on certain specific dates of service, he provided a substantial number of physical therapy treatments to

himself; the Respondent, however, failed to record Office Notes or flow sheets corresponding to or verifying such treatments. In other instances, the Respondent wrote Office Notes which did not indicate that he provided/received physical therapy services, although he made such representations in the Statement. In addition, although the Respondent did not record any further Office Notes after June 12, 1998, he represented in the Statement that he provided an additional 28 sets of physical therapy treatments to himself. A list of the Respondent's Office Notes and corresponding dates set forth in his Statement is set forth in **Attachment A,** which is attached hereto and incorporated herein, and sets forth: in column one, the dates of the Office Notes written by the Respondent (indicating whether license number was recorded); in column two, dates of treatments with documentation in the Office Notes; and in column three, dates of treatments without documentation in the Office Notes).

22. The Respondent's first Office Note, dated August 9, 1997, recounts the circumstances surrounding his motor vehicle accident on that date. The Respondent documented that he performed a physical self-examination to assess the extent of his injuries, noting spasms in the lumbar and thoracic regions, exquisite trigger points, tenderness, and bilateral positive straight leg raise at 45 degrees. The Respondent documented that his self-administered neurovascular and sensory examinations were "grossly within normal limits in the bilateral lower extremities." The Respondent noted that his right foot and ankle complex were "edeminous" (sic), although no objective measurements were documented.

23. The Respondent's initial evaluation was deficient in that it did not include parameters such as range of motion or muscle testing measurements of the spine or extremities, posture evaluation, or comments regarding functional limitations in activities of living, which would have been indicated under the circumstances. In addition, the Respondent did not document specified treatment goals other than the statement following the subheading "Plan," which noted that "I'm going to go ahead and give it a few weeks of conservative treatment including over the counter medication, including Ibuprofen for reduction of inflammation, as well as daily, if not twice daily, physical therapy treatments and, hopefully, this whole thing will resolve without further intervention."

24. Under the subheading "Treatment," the Respondent documented that:

> "TREATMENT: [t]he patient was started on a course of physical therapy to include thermal modalities, specifically cryotherapy over the next 72 hours with interferential electrical stimulation for muscle spasm reduction as well as decrease in edema, along with the appropriate myofascial release techniques to be performed to the patient's tolerance."

The Respondent's documentation was deficient in that he failed to note what part(s) of his body he was treating with these techniques, particularly the manual therapy techniques he purportedly applied to his back.

25. Other aspects of this Office Note are also written in the past tense (e.g., "[t]he hope **was** that the symptomalogy would be short lived and that no formal medical intervention would be necessitated or required."), indicating the

possibility that this and other Office Notes were not written contemporaneously with the dates recorded in the Office Note. (emphasis added)

26. At the conclusion of the "Treatment" portion of this record, the Respondent noted that "[a]ll of the appropriate precautions and contraindications, as well as the limitations of physical therapy, have been reviewed at length with the patient." The Respondent did not document how it would be possible to have such a discussion, since he was both the provider of the physical therapy as well as the patient receiving such treatment. The Respondent made similar representations regarding patient discussions in subsequent Office Notes.

27. In his Office Note for this date, the Respondent failed in other respects to record adequate documentation in his physical therapy record. The Respondent's license number and signature are not recorded and signed, respectively, and his initial evaluation does not contain sufficient documentation necessary for a complete assessment or physical examination for purposes of providing physical therapy. In addition, the Respondent could not appropriately execute some of the evaluation procedures and treatment interventions he represented he performed in this Office Note, such as performance of straight leg raising testing, palpation of certain areas of his back, deep tendon reflex testing and manual therapy techniques he applied to his own back.

28. Other questionable representations also occur in the Respondent's initial Office Notes. For example, in his August 11, 1997 Office Note, the Respondent documented that he had had a lengthy discussion regarding his

condition with Dr. Higgins. The Respondent noted that Dr. Higgins recommended continuing the "previously described course of treatment" as well as possible consideration of an "MRI, as well as the possibility of epidural blocks." According to Dr. Higgins' own medical records, however, he did not personally evaluate the Respondent until September 2, 1997.

29. The Respondent's note for this date does not have measurable findings except for straight leg raising testing. In addition, the Respondent documented tenderness on palpation, again performed on himself. The Respondent then underwent an MRI of his lumbosacral spine on September 9, 1997. The MRI report indicates that "[t]his is a normal MRI examination of the lumbosacral spine."

30. The Respondent's Office Notes between August 9, 1997 and September 26, 1997 have no signatures or license numbers documented. Starting with the October 17, 1997 entry, the Respondent's Office Notes are signed intermittently. Some of the signatures, when present, appear to be variable. In none of the subsequent entries did the Respondent document his license number.

31. Throughout the Respondent's Office Notes, the Respondent documented that he self-administered certain physical therapy treatments which either cannot be self-administered or which would be extremely difficult to administer in a competent manner (e.g., massage and manual therapy to the back; ultrasound to the back; active assistive and passive range of motion

exercises). These treatments require treatment administered by a physical therapist separate and distinct from the individual receiving the treatment. *See* **Attachment B**, which is attached hereto and incorporated herein (which identifies examples of therapeutic interventions purportedly self-administered by the Respondent).

32. Although some on the Respondent's Office Notes do contain objective findings, it is improbable that the Respondent could obtain reliable measurements on himself such as the ones he recorded (e.g., manual muscle testing, range of motion and sensory testing, palpation, deep tendon reflex testing, and straight leg raising testing). The Respondent recorded such measurements under such questionable circumstances throughout his Office Notes. *See* **Attachment B** (which identifies examples of self-assessments/objective findings purportedly measured by the Respondent).

33. Throughout his Office Notes, the Respondent failed to document a flow sheet for each date of service and the identity of the actual provider of care.

34. Throughout his Office Notes, the Respondent failed to adequately and completely document the location of specific treatment interventions and responses to such treatments. Although the Respondent documented complaints of multiple injuries, his notes were often incomplete or non-specific regarding what body parts he was applying physical therapy treatment. For example, in his Office Note, dated October 28, 1997, the Respondent documented the following:

> "TREATMENT: The patient continues on an aggressive course of physical therapy to include

> thermal modalities, ultrasound, deep massage with myofascial techniques, along with the appropriate stretching and strengthening exercises to include isometric, isotonic and isokenetic exercises all being performed to his tolerance. In addition, the patient continues on an aggressive home program of self-stretching and strengthening exercises utilizing McKenzie and Williams techniques, along with the appropriate postural and biomechanical modifications in the work place."

35. In addition, the Respondent failed to consistently document the specific response to treatment for each body part (e.g., Office Notes, dated October 21, 1997 and October 28, 1997).

36. On December 22, 1997, the Respondent underwent left knee arthroscopy, performed by Dr. Higgins. The Respondent recorded an Office Note, dated December 23, 1997, in which he recorded a self-evaluation of his knee. The Respondent then wrote a follow-up Office Note, dated December 29, 1997, which contained a further post-operative self-assessment of his condition. In this entry, the Respondent did not note that he self-administered any physical therapy treatments. Notwithstanding this, however, the Respondent listed in his billing record for December 29, 1997, that he self- administered a hydrocollator pack, electrical stimulation, and underwent therapeutic exercise and therapeutic activities.

37. On January 22, 1998, the Respondent wrote in an Office Note that his lumbar symptoms have "markedly improved." The Respondent's next Office Note is dated February 26, 1998. The Respondent's Statement indicates that during this intervening period, he self-administered 14 physical treatments. The

Respondent failed to write an Office Note or flow sheet corresponding to these 14 treatments, however. The Respondent did not identify what body part(s) were being treated with the multiple passive modalities purportedly administered.

38. In several instances throughout the Respondent's Office Notes, the Respondent recorded that he self-administered physical therapy treatment modalities which would be extremely difficult to accomplish in light of his condition. For example, in his May 6, 1998 Office Note, the Respondent documented that:

> "Mr. Clarke awakens today with excruciating right hip, lower extremity and foot and ankle discomfort, as well as paraesthesia and numbness into the foot and ankle complex with exquisite trigger points, tenderness over the greater trochanter and the web space between digits four and five. In addition, there is excruciating and unbearable thoracolumbar discomfort, restricted mobility and associated muscle spasms..."

39. Despite the Respondent's characterization of his discomfort as being "excruciating and unbearable," the Respondent recorded a self-assessment that included muscle spasm palpation and straight leg raising techniques. It is improbable that such testing could be accurately and objectively self-administered, particularly in view of the Respondent's assessment of his level of pain.

40. After making this self-assessment, the Respondent documented that he treated himself with thermal modalities, ultrasound, electrical stimulation, posture and gait training. The Respondent's self-administration of such

treatments is highly questionable in view of his own characterization of the level of his pain/discomfort.

41. During the summer of 1998, the Respondent continued to be evaluated for low back and leg pain by Dr. Higgins.

42. During this time, the Respondent then reported that he sustained a shoulder injury which he attributed to the automobile accident. On January 5, 1999, the Respondent underwent right shoulder arthrosopic surgery, performed by Dr. Higgins at Montgomery General Hospital.

43. Several differing accounts exist as to how the Respondent sustained this injury. For example, in a medical record entry dated September 8, 1998, Dr. Higgins noted that the Respondent reported to him that on September 5, 1998, he "tripped and fell" in his home and sustained an anterior shoulder dislocation which he self-reduced. There is no indication in Dr. Higgins' report that the Respondent sought emergency medical or physician care directly after sustaining this injury. Dr. Higgins' note does not indicate that the Respondent's injury occurred because of the Respondent's automobile accident or a condition which resulted because of it.

44. In a follow-up entry, dated October 19, 1998, however, Dr. Higgins wrote the following: "addendum 9/8/98; Mr. Clarke tripped and fell because his right leg gave out on him. This caused him to fall to the floor and dislocate his shoulder."

45. In a subsequent entry, dated November 19, 1998, Dr. Higgins reported that "[the Respondent] dislocated his shoulder from a fall when his leg gave out on him because of his back pain."

46. The Respondent's statements, as set forth in his initial evaluation and representations to other consultants, are not entirely consistent with those provided to his treating physician, Dr. Higgins. In his initial self-evaluation, the Respondent did not state any injury or treatment to the right shoulder. In an oral history provided to a consultant, Dr. Kozak, on February 19, 1999, the Respondent represented that with regard to the accident, "I also injured my left knee and right shoulder."

47. Sequentially following the Respondent's Office Notes are a series of physical therapy records written by Michelle L. Blount (License Number 19401), a physical therapist employed by the Respondent. These entries, which are also on the Respondent's letterhead, identify the subject as "James R. Clarke," and are signed by Ms. Blount. Ms. Blount purportedly provided physical therapy treatment to the Respondent after his January 5, 1999 surgery.

48. Ms. Blount's first entry is dated January 6, 1999[1]. It is typewritten and documents her evaluation of the Respondent, including physical findings, current treatments, and a treatment plan. This evaluation was individually addressed and sent to two physicians who were involved in providing ongoing medical care to the Respondent.

49. Ms. Blount's subsequent entries are in two formats: the majority of Ms. Blount's daily notes were documented in a computerized format (January 9,

[1] The Statement, however, lists the evaluation as occurring on January 7, 1999.

1999 to February 11, 1999; February 25, 1999 to March 1, 1999; and March 10, 1999 to March 1, 2000); interspersed in the computerized daily notes are a series of handwritten notes written and initialed by Ms. Blount (February 16, 1999 to February 24, 1999; and March 3, 1999 to March 8, 1999).

50. During the civil litigation that ensued as a result of the Respondent's injuries, Ms. Blount was deposed with respect the physical therapy treatments she provided to the Respondent. Among other topics, Ms. Blount was questioned about the fact that on several dates, Mr. Clarke, though his professional association, submitted claims for reimbursement for physical therapy services, notwithstanding the fact that Ms. Blount had not written corresponding Office Notes or flow sheets for those dates of service. After being apprised of this fact, Ms. Blount, after the deposition, handwrote physical therapy notes for these dates, which she characterized as a "reconstruction" the treatment(s) she provided. When she initially wrote these notes, she designated the date numerically, with the year written as "00". After it was brought to her attention that she provided these treatments in 1999, Ms. Blount altered the handwritten notes by striking or crossing out the year "00", and designating the year as "99". Ms. Blount initiated each alteration.

51. After generating a computerized entry for March 15, 1999, Ms. Blount's next computerized entry is dated December 14, 1999. On that date, Ms. Blount documented that she evaluated the Respondent for shoulder pain. The December 14, 1999 entry, however, did not contain adequate documentation of an evaluation or reevaluation that would have been necessary following a

purported nine-month hiatus form therapy. Ms. Blount formulated two Daily Notes for December 1999.

52. The next note signed by Ms. Blount is a computerized note, dated March 1, 2000. In this note, Ms. Blount recorded that the Respondent had experienced low back pain. This note failed to reflect a full evaluation or reevaluation as would be required after such a lengthy hiatus from therapy.

53. The Respondent generated a Statement of Professional Services on his letterhead for the period January 7, 1999 through March 1, 2000. The Respondent was identified as the patient, and his diagnosis was recorded as "right shoulder recurrent dislocation-surgery." Ms. Blount purportedly performed these services. In total, 23 treatment dates are listed in the Statement for this period. In his claims for reimbursement, the Respondent listed the treating provider as "James R. Clarke, P.T." In addition, the Respondent submitted a claim for reimbursement to his insurance carrier for at least one date of service, March 17, 1999, for which there is no supporting physical therapy treatment record. Moreover, Ms. Blount herself underwent shoulder surgery on March 16, 1999, and was not in a position to provide physical therapy services to the Respondent on this date.

54. After the 1997 accident, the Respondent, while continuing to engage in the practice of physical therapy, was prescribed various forms of narcotic analgesics, such as Percocet, Tylenol with Codeine, Oxycodone, and OxyContin; and other habituating medications, such as Valium, by his treating

physicians. The Respondent continued taking such medications on a regular basis until at least March 2001 for pain, insomnia and anxiety.

55. The Respondent documented in his Office Note, dated August 22, 1997, that he had started taking Percocet for pain. There is no physician note in the record that documents that the Respondent was being prescribed Percocet at this time, however. Dr. Higgins' initial evaluation, dated September 2, 1997, noted that the Respondent was taking Percocet.

56. The Respondent's subsequent Office Notes also document the Respondent's use of controlled substances. For example, in his note dated November 12, 1997, the Respondent documented his use of Vicodin, a Schedule III controlled substance. In his note dated February 26, 1998, the Respondent documented that he had been prescribed Tylenol with Codeine. In his note dated May 6, 1998, the Respondent documented his use of Medrol dose pack and Demerol "for pain relief."

57. The Respondent's treating physicians also documented that the Respondent was being treated with controlled substances. In a note dated October 2, 1998, for example, Dr. Higgins noted that the Respondent needed "long term pain management." Thereafter, Dr. Higgins continued to prescribe narcotic analgesic and other prescriptions for the Respondent.

59. The Board conducted a pharmacy survey with respect to this matter, the results of which are attached hereto and incorporated herein as **Attachment C.** Attachment C identifies prescriptions for controlled substances

and other medications provided to the Respondent by the various physicians involved in treating the Respondent.

60. Other physicians providing treatment to the Respondent also prescribed controlled substances for him. The Respondent consulted a physiatrist, Joseph Y. Lin, M.D. on August 6, 1998. On this date, Dr. Lin prescribed Percocet for the Respondent, and continued to do so until June, 1999, after which he prescribed OxyContin, until August 1999. In notes dated May 21, 1999 and June 7, 1999, Dr. Lin noted that the Respondent needed "pain management." In a note dated September 20, 1999, Dr. Lin commented that the Respondent was having "withdrawal symptoms" after attempting to curtail his medication usage. A survey of Dr. Lin's prescriptions as documented in his medical records is attached hereto and incorporated herein as **Attachment D**.

61. The Respondent also consulted a psychiatrist, Jack D. Blaine, M.D., after his injuries. In a note dated March 23, 1999, Dr. Blaine noted that the Respondent was "addicted to Percocet." In a subsequent note, dated September 13, 1999, Dr. Blaine noted that the Respondent was not using any opiates at that point for a three-to-four week period.

62. One of the Respondent's other consulting physicians, Dr. Kozak, also commented on the Respondent's controlled substance usage, noting in his February 19, 1999 consultation report that the Respondent had "managed to continue working but require[d] substantial Percocet use, ranging from one to five tablets per day, in order to keep his work schedule."

63. The Respondent's actions, as set forth above, constitute the following violations of the Act: to an extent that impairs professional competence, habitually uses any: (i) drug, in violation of H.O. § 13-316(9); violating any provision of this title or rule or regulation adopted by the Board, in violation of H.O. § 13-316(16); commits an act of unprofessional conduct in the practice of physical therapy, in violation of H.O. § 13-316(20); and fails to meet accepted standards in delivering physical therapy, in violation of H.O. § 13-316(26).

64. In addition, the Respondent's actions, as set forth above, constitute the following violations of COMAR 10.38.03.02: the physical therapist shall exercise sound professional judgment in the use of evaluation and treatment procedures, in violation of COMAR 10.38.03.02 A; the physical therapist shall work within the physical therapist competency in physical therapy evaluation and treatment, in violation of COMAR 10.38.03.02 Q; and failed to comply with documentation requirements in violation of COMAR 10.38.03.02-1.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's actions constitute the following violations of: H.O. § 13-316(9) (to an extent that impairs professional competence, habitually uses any: (i) drug); H.O. § 13-316(16) (violating any provision of this title or rule or regulation adopted by the Board): H.O. § 13-316(20) (commits an act of unprofessional conduct in the practice of physical therapy); H.O. § 13-316(26) (fails to meet accepted standards in delivering physical therapy); COMAR 10.38.03.02 A (the physical therapist shall exercise sound professional judgment

complete the course pursuant to the above terms shall constitute a violation of his probation.

c. Within six (6) months of the date of this Consent Order, the Respondent shall enroll in and successfully complete a course in physical therapy documentation/ recordkeeping. As part of the approval process, the Respondent shall submit to the Board a written description of the course and pertinent information regarding the course. The Board reserves the right to request from the Respondent further information regarding the course, and further reserves the right to reject the course the Respondent submits to fulfill this condition. In the event the Board rejects the course that is submitted by the Respondent, the Respondent shall submit an alternative course, subject to the terms set forth above. The Respondent shall submit written verification of his successful completion of the course within ten (10) business days after completing the course. The Respondent shall be responsible for all costs associated with the taking of this course. The Respondent understands and agrees that his failure to successfully complete the course pursuant to the above terms shall constitute a violation of his probation.

APTA course taken 10/9/02 ad

d. Commencing after the conclusion of the first six (6) months of the Respondent's probation, and continuing thereafter during the remaining period of the Respondent's probation, the Respondent shall undergo a review of his physical therapy treatment records by a reviewer selected by the Board. Such reviews will occur on a quarterly basis as designated by the Board. In the event that the Respondent is not treating patients at any point during this time period, the Respondent shall so notify the Board and this condition shall be tolled until such time as the Respondent resumes treating patients, after which the Respondent shall be subject to such reviews according to the terms set forth above.

AND BE IT FURTHER ORDERED that if the Respondent violates any of the terms or conditions of this Consent Order, including the probationary terms or conditions as set forth herein, then the Board, after a determination of violation and notice, and an opportunity for a hearing, may impose any other disciplinary

in the use of evaluation and treatment procedures); COMAR 10.38.03.02 Q (the physical therapist shall work within the physical therapist competency in physical therapy evaluation and treatment); and COMAR 10.38.03.02-1 (failed to comply with documentation requirements.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 17th day of September 2002, by the Board, on the affirmative vote of a majority of its members then serving, hereby:

ORDERED that the Respondent's license to practice physical therapy is hereby **SUSPENDED** for a period of **SIXTY (60) DAYS**; and be it further

ORDERED that the said **SUSPENSION** shall be immediately **STAYED**; and be it further

ORDERED that the Respondent shall be placed on **PROBATION** for a period of **TWO (2) YEARS**, subject to the following terms and conditions:

a. During the first six (6) months of the Respondent's probation, the Respondent shall undergo random drug screening by a Board-approved laboratory on a weekly basis, or as ordered by the Board. In the event that such testing indicates a positive finding for any non-prescribed medication, such a finding shall constitute a violation of the Respondent's probation.

b. Within one (1) year of the date of this Consent Order, the Respondent shall enroll in and successfully complete a law and ethics course that is approved by the Board. The Respondent shall submit written verification of his successful completion of the course within ten (10) business days after completing the course. The Respondent shall be responsible for all costs associated with the taking of this course. The Respondent understands and agrees that his failure to successfully

sanctions it deems appropriate, including suspension or revocation, said violation of probation being proved by a preponderance of evidence; and be it further

ORDERED that the conditions of this Consent Order be, and the same is hereby, effective as of the date of this Order; and be it further

ORDERED that the charges under H.O. 13-316(2), (13), (15), (21), and (24) are hereby **DISMISSED**; and be it further

ORDERED that the Respondent shall practice physical therapy in accordance with the Maryland Physical Therapy Act, and in a competent manner; and be it further

ORDERED that in the event the Board finds for any reason in good faith that the Respondent has violated any provision of Title 13 of the Health Occupations Article, Annotated Code of Maryland or the regulations thereunder, the Board, after notification to the Respondent, and an opportunity for a hearing, may take immediate action and may impose any lawful disciplinary sanctions it deems appropriate, including but not limited to revocation or suspension of the Respondent's license to practice physical therapy; and be it further

ORDERED that only after the Respondent has completed his two (2) year probationary period, the Respondent may petition the Board for termination of the probationary status and reinstatement of his license without further conditions or restrictions, provided that he has fulfilled all the terms and conditions of probation set forth herein, is not in violation of this Consent Order, and there are no outstanding complaints against the Respondent. If the Board determines that the terms of probation have not been successfully completed, then the Board may

modify one or more conditions upon which the Respondent was placed on probation, upon notice to the Respondent. However, if the Respondent fails to make any such petition, then the probationary period status shall continue indefinitely, subject to the conditions set forth in this Order; and be it further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and be it further

ORDERED that this is a **FINAL ORDER** and as such is a public document pursuant to Md. State Gov't. Code Ann. §§ 10-611 et seq. (1999).

9-17-02
Date

Penelope D. Lescher, P.T., Chairperson
Board of Physical Therapy Examiners