IN THE MATTER OF	*	**BEFORE THE STATE BOARD**
DAVID COSTEA, P.T.	*	**OF PHYSICAL THERAPY**
LICENSE NO.: 18091	*	**EXAMINERS**

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

CONSENT ORDER

The State Board of Physical Therapy Examiners (the "Board") charged **DAVID COSTEA, P.T. (D.O.B. 1/17/66) (the "Respondent") License Number 18091**, with violation of certain provisions of the Maryland Physical Therapy Act, (the "Act") codified at Md. Health Occ. Code Ann. ("Health Occ.") tit. 13, (2005).

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

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee or holder:
>
> (15) Violates any provision of this title or rule or regulation adopted by the Board;
>
> (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy; [and]
>
> (25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy care.

The specific regulations under the Board's Charges are:

COMAR 10.38.03.02-1Requirements for Documentation

A. The physical therapist shall document legibly the patient's chart each time the patient is seen for:

(1) The initial visit, by including the following information:

(a) Date;

(b) Condition, or diagnosis, or both for which physical therapy is being rendered,
(c) Onset;
(d) History, if not previously recorded;
(e) Evaluation and results of test (measurable and objective data);
(f) Interpretation;
(g) Goals;
(h) Modalities, or procedures, or both, used during the initial visit and the parameters involved including the areas of the body treated;
(i) Plan of care including suggested modalities, or procedures, or both, number of visits per week, and number of weeks; and
(i) Signature, title (P.T.), and license number.

(2) Subsequent visits, by including the following (progress notes):
(a) Date;
(b) Cancellations, no-shows;
(c) Subjective response to treatment;
(d) Modalities, or procedures, or both, with any changes in the parameters involved and areas of the body treated;
(e) Objective functional status;
(f) Response to current treatment;
(g) Continuation of or changes in plan of care; and
(h) Signature, title (PT), and license number, and the flow chart may be initialed.

(3) Reevaluation, by including the following information in the report, which may be in combination with visit note, if treated during the same visit:
(a) Date;
(b) Number of treatments;
(c) Reevaluation, tests, and measurements of areas of body treated;
(d) Changes from previous objective findings;
(e) Interpretation of results;
(f) Goals met or not met and reasons;
(g) Updated goals;
(h) Plan of care including recommendation for follow-up; and
(i) Signature, title (PT), and license number.

(4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist;
(a) Date;
(b) Reason for Discharge;
(c) Objective functional status;
(d) Recommendation for follow-up, and
(e) Signature, title (PT), and license number.

On August 11, 2006, a Case Resolution Conference ("CRC") was held at the Board's offices in an attempt to resolve the Charges pending against the Respondent prior to a hearing. As a result of negotiations between the parties at the CRC, the parties entered into the following Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

The Board finds:

I. Background

1. The Respondent is currently licensed to practice physical therapy in the State of Maryland.

2. The Respondent was first licensed in 1995, being issued license number 18091.

3. The Respondent's license expires on May 31, 2007.

4. The Respondent worked as a staff physical therapist for University of Maryland Medical Center ("UMMC") for several months in 2004 ending on June 30, 2004, when he resigned.

5. In November 2004, the Board received a complaint from the UMMC indicating that the Respondent had resigned in lieu of termination because of his inability to comply with departmental standards regarding documentation and billing of physical therapy services.

6. The Board's investigation revealed the following:

7. In or around June 2004, the Respondent's immediate supervisor, NR,[1] conducted a chart review of the Respondent's patient care, documentation and billing practices as part of his new employee orientation to the UMMS rehabilitation department. Chart reviews, including billing, are typically performed during a new employee's training period to assure that the

1 The names of the witnesses are omitted for confidentiality purposes. The names of the witnesses will be provided to the Respondent by the Administrative Prosecutor upon request.

employee is in compliance with departmental and State standards.

8. Beginning on or around June 9, 2004, NR performed almost daily reviews and audits of the Respondent's documentation and billing of patient care. During her chart reviews and billing audits she noted numerous documentation and billing errors and inconsistencies.

9. As a result of the numerous errors noted in the billing audits and documentation reviews, the Respondent was required to attend scheduled weekly "performance management" meetings with his immediate supervisor, NR, and the manager of the Rehabilitation Department, BK. The purpose of the performance management meetings was to review the Respondent's compliance with departmental standards for documentation, billing and patient care. Weekly performance management meetings took place on June 9, 2004, June 16, 2004, June 23, 2004, and June 30, 2004.

10. Throughout the process of supervising the Respondent's compliance with the UMMS and State documentation standards, NR noted the following findings on "Key Incident Reports:"[2]

DATE OF BILLS REVIEWED	**TOPIC**	**DISCUSSION**	**PLAN**	**DATE REVIEWED WITH [RESPONDENT]**	**INITIALS**
6/9/04	Chart Review	One chart reviewed 5 Billing errors for one chart review		6/9	NR
6/9/04	Billing Audits	5 Patient Charts Reviewed, 2 Billing errors 3 Documentation errors		6/9	NR

2 "Key Incident Reports" are a management tool used by UMMC supervisors to address specific issues with employees.

6/11	Billing Audits	Two Charts Reviewed 0 Billing Errors		6/11	NR
6/13	[same]	Three charts reviewed Two charts with one error each		6/14	NR
6/13	[same]	One chart reviewed One Billing error (error above not corrected accurately)		6/16	NR
6/14	[same]	Five charts reviewed Two charts with two errors each		6/16	NR
6/16	[same]	One chart reviewed 0 billing errors		6/18	NR
6/17	[same]	One chart reviewed 0 billing errors		6/18	NR
6/18/04	Billing Audits	2 charts reviewed/ audited 0 errors			
6/21/04	[same]	3 charts audited 1 error; [Respondent] brought this to [NR's] attention and explored on his own why this occurred		6/21/04	
6/22	[same]	3 charts audited, no billing errors. Assessment section on		6/25/04	

		evaluation needs more info			
6/23	[same]	5 charts audited, no billing errors rollup error[3]: [Respondent] noted 3.5 hrs Tx care; Billing supported 3.0 hrs; [Respondent] notified and made appropriate changes		6/24/04	
6/24	[same]	5 charts audited 1 documentation did not fully support charges; charged for 3 units of eval when 3 other pts were charged 2 units of evaluation for close to same level of care.		6/25/04	
6/25	[same]	3 charts reviewed: no billing errors		6/29/04	
6/25/04	Documentation	Reviewed charges for last 2 days – appropriate for services rendered reviewed,	To review in more detail at weekly meeting	To be addressed at next weekly meeting	

3 According to NR, staff physical therapists are expected to "rollup" or perform a "daily plan and analysis" at the end of every work day to assure that the documentation and billing conform to the care provided on that date and to track time spent on administrative tasks vs. patient care.

		briefly, components for assessment section of eval.			
6/28/04	Time management	[Respondent] notified NR that he missed inservice that [day]	[Respondent] to check monthly calendar every am		
6/29/04	Documentation	[NR] approached [Respondent] about one hr of documentation time completed Monday for last Friday. Per Respondent, goals/Plan of Care needed to be updated on 2 pts.; one of these pts had a lengthy hospital stay. [Respondent] was unsure of best way to update goals & plan of care in this situation. [NR] reviewed this using one of those pts as an example.	[Respondent] to contact [NR] or other available staff member with enough experience at UMMS to answer this question.		
6/28/04	Billing Audits	2 charts audited 1 billing error		6/30/04	
6/29	[same]	4 charts audited—no documentation noted in charts by 9 am on 6/30/04, by		6/30/04	

		10:15, 4 charts audited documentation in chart- 0 billing errors			

11. On the morning of June 30, 2004, NR discovered that the Respondent had billed for services rendered on June 29, 2004 but did not document the care he provided on that date.

12. NR noted the following on a Key Incident Report dated June 30, 2004:

> During billing audits of [Respondent's] charges for 6/29/04, noted no documentation in chart for 4 out of 4 charts. [NR] approached [Respondent]. He stated he had them and would have them in the charts within ½ hour. Reviewed with [Respondent] that documentation is to be in chart the same day services are rendered. One hour later, documentation for those 4 charts was in the chart.

13. When NR asked the Respondent about the missing documentation, he stated that he had finished it and had not yet placed it in the patients' charts. He did not produce it for NR to review.

14. NR immediately reported the lack of documentation on June 29, 2004 to BK.

15. A few moments later, BK asked the Respondent himself about the missing documentation. The Respondent admitted that he had seen seven (7) patients on June 29 and had not written any documentation on any of them.

16. Within an hour of the Respondent's conversation with BK, on the morning of June 30, 2004, the Respondent completed documentation for five (5) of the seven (7) patients he had seen the previous day but was unable to complete documentation for two (2) of the patients because they had been discharged and their charts had been transferred to the Medical Records Department.[4]

17. Later in the day on June 30, 2004, BK and NR met with the Respondent in a

4 The Respondent completed the documentation for the two (2) discharged patients before leaving the facility on June 30, 2004.

performance management meeting to discuss the Respondent's ongoing documentation and communication problems and seeking an explanation for the Respondent's misleading statements to NR. When asked for an explanation for his failure to document, the Respondent replied that, "[he] did not have time." However, BK noted that the Respondent had not worked extensive hours on June 29, 2004; having clocked-in at 8:05 a.m. and clocked-out at 5:05 p.m.

18. The Respondent resigned in lieu of termination on June 30, 2004.

19. By failing to properly document patient care as described in paragraphs 7-18, the Respondent violated Health Occ. §13-317 (25) which requires that physical therapists meet accepted standards in delivery of physical therapy care and Health Occ. § 13-317(15) which requires that physical therapists adhere to any rule or regulation adopted by the Board. Specifically, the Respondent violated the Board's regulation codified at COMAR 10.38.03.02-1 by failing to comply with the Board's requirements for documentation. By failing to disclose to his supervisor that he had not completed the documentation for all of the patients he saw on June 29, 2004 after being asked directly whether he had done so, the Respondent committed an act of unprofessional conduct in violation of Health Occ. § 13-317 (19).

CONCLUSIONS OF LAW

The Board finds that the Respondent violated Health Occ. §§ 13-316 (15), (19), (25) and COMAR 10. 38. 03.02-01

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and agreement of the parties, it is this 19th day of September, 2006, by a majority of a quorum of the Board

ORDERED that the Respondent's license to practice physical therapy in the State of

Maryland is REPRIMANDED; and it is further

ORDERED that the Respondent shall be placed immediately on PROBATION for a period of two (2) years, subject to the following conditions:

a. During the first year of probation, the Respondent shall enroll in and successfully complete a Board-approved Maryland law course;

b. During the first year of probation, the Respondent shall enroll in and successfully complete a Board-approved documentation course;

c. The above referenced courses shall be completed in addition to any other continuing education requirements necessary for continued licensure;

d. Throughout the probationary period, the Respondent shall submit **quarterly** reports from a supervisory physical therapist at his place of employment indicating his continued compliance with practice standards, including documentation; and it is further

ORDERED that the Respondent shall permit the Board review his treatment records as follows:

a. The Respondent shall permit the Board to review the treatment and billing records of at least ten (10) patients, five (5) of which shall be within the first sixty (60) days of the probationary period and an additional five (5) patients within the first year of the probationary period.

b. The Respondent shall provide to the Board the complete record for each patient whose records are to be reviewed.

c. The Respondent shall comply with all written recommendations made by the Board. Failure to comply with the Board's written recommendations shall be

deemed to be a violation of the Consent Order.

ORDERED that this Consent Order is effective as of the date of its signing by the Board; and it is further

ORDERED that should the Board receive a report during the probationary period that the Respondent has violated the Act or if the Respondent violates any conditions of this Order of probation, after providing the Respondent with notice and an opportunity for a hearing, the Board may take further disciplinary action against Respondent, including suspension or revocation of his license. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of this Order of probation shall be on the Respondent to demonstrate compliance with the Order or conditions; and it is further

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

ORDERED that at the end of the probationary period, the Respondent may petition the Board to be reinstated without any conditions or restrictions on his license, and it is further

ORDERED that the Respondent shall be responsible for all costs associated with this Consent Order; and it is further

ORDERED that for purposes of public disclosure, as permitted by Md. State Gov't. Code Ann. § 10-617(h) (2004 Repl. Vol. and 2005 Supp.) this document consists of the foregoing Findings of Fact, Conclusions of Law, and Order, and that the Board may also disclose same to any national reporting data bank to which it is mandated to report.

September 19, 2006
Date

Margery Rodgers, P.T., Chair
State Board of Physical Therapy Examiners

CONSENT OF DAVID COSTEA, P.T.

I, **DAVID COSTEA, P.T., License Number 18091** affixing my signature hereto, acknowledge that:

1. I am represented by counsel and I have reviewed this Consent Order with my attorney.

2. I am aware that I am entitled to a formal evidentiary hearing before the Board, pursuant to Md. Health Occ. Code Ann. § 13-317 (2005 Repl. Vol.) and Md. State Gov't. Code Ann. §§10-201 *et seq*. (2004 Repl. Vol. & 2005 Supp.) I waive any right to contest the terms and findings herein, and I waive my right to a full evidentiary hearing and any right to appeal this Consent Order as set forth in § 13-317 of the Act and Md. State Gov't. Code Ann. §§10-201 *et seq*.

3. I acknowledge the validity of this Consent Order as if entered after a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law.

4. I voluntarily admit to the foregoing Findings of Fact, Conclusions of Law and Order and submit to the terms and conditions set-forth herein as a resolution of the Charges against me. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, and, following proper procedures, I may suffer disciplinary action, which may include revocation of my license to practice physical therapy in the State of Maryland.

5. I sign this Consent Order without reservation as my voluntary act and deed. I acknowledge that I fully understand and comprehend the language, meaning, and terms of this Consent Order.

9SEPT 2006
Date

David Costea P.T.
David Costea, P.T.

Approved by:
Michael Baxter, Esq.

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF BALTIMORE CITY

I HEREBY CERTIFY THAT on this 8 day of SEPTEMBER 2006, before me, a Notary Public for the State of Maryland and the City/County aforesaid, personally appeared David Costea, P.T., and made oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

Kim E Davenport
Notary Public

My Commission Expires: 11-10-2009

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KIM E. DAVENPORT
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires November 10, 2009