IN THE MATTER OF	*	**BEFORE THE STATE BOARD**
ALI D. KANJI, P.T.	*	**OF PHYSICAL THERAPY**
License No.: 22133	*	**EXAMINERS**
Respondent	*	**Case Numbers: PT 15-50- A & 15-67-A**

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CONSENT ORDER

On February 2, 2017, the Maryland State Board of Physical Therapy Examiners (the "Board") charged Ali D. Kanji, P.T. (the "Respondent") with violations of certain provisions of the Maryland Physical Therapy Act (the "Act"), Md. Code Ann., Health Occ. ("H.O.") §§ 13-101 *et seq.* (2014 Repl. Vol. & 2014 Supp.).

Specifically, the Board charged the Respondent with violations of 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 or restricted license to any applicant, reprimand any licensee or holder of a restricted license, place any licensee or holder of a restricted license on probation, or suspend or revoke a license or restricted license if the applicant, licensee or holder:
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> ...
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> (12) Willfully makes or files a false report or record in the practice of physical therapy or limited physical therapy;
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> ...
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> (14) Submits a false statement to collect a fee;
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> (15) Violates any provision of this title or rule or regulation adopted by the Board;
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> ...
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> (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy;
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> (20) Grossly overutilizes health care services;
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> ...
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> (24) Willfully and without legal justification, fails to cooperate with a lawful investigation conducted by the Board;
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> (25) Fails to meet accepted standards in delivering physical therapy...[.]

The Board further charged the Respondent with violating the Board's Code of Ethics, specifically Md. Code Regs.10.38.02.01 F that provides:

> The physical therapist ...shall report to the Board of Physical Therapy Examiners all information that indicates a person is allegedly performing, or aiding and abetting, the illegal or unsafe practice of physical therapy. .

The Board also charged the Respondent with violations of the Md. Code Regs. 10.38.03.02-1 Requirements for Documentation:

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

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

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

(2) Subsequent visits, by including the following information (progress notes):

(a) Date;
(b) Cancellations, no-shows;
(c) Modalities, or procedures or both, with any changes in the parameters involved and areas of body treated;
(d) Objective status;
(e) Response to current treatment, if any;
(f) Changes in plan of care; and
(g) Signature, title (PT), and license number, although the flow chart may be initialed.

(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 since the initial evaluation or last reevaluation;
(c) Reevaluation, tests, and measurements of areas of the body treated;
(d) Changes from previous objective findings;
(e) Interpretation of results;
(f) Goals met or not met and reasons;
(g) Updated goals;
(h) Updated plan of care including recommendations for follow-up; and
(i) Signature, title (PT), and license number;

On March 21, 2017, a conference with regard to this matter was held before the Board's Case Resolution Conference ("CRC"). As a result of the CRC, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

I. Procedural History

1. At all times relevant to these charges, the Respondent was licensed to practice physical therapy in the State of Maryland. The Respondent was originally licensed on January 17, 2007. His license is scheduled to expire on May 31, 2017.

2. The Respondent is the co-owner and clinical director of "Practice A,"[1] a physical therapy practice with several office locations.[2]

[1] Names of patients, other individuals and facilities are confidential.
[2] The Respondent's co-owner is identified herein as PT 3.

3. On or about June 19, 2015, the Complainant, a PT who had been employed at Practice A from April 2015 to June 2015, reported to Board staff several concerns regarding inappropriate treatment, scheduling and billing practices she had observed while employed at Practice A, including the scheduling and billing of Medicare patients.[3]

4. The Complainant reported that PT 1, a PT then employed at Practice A, had two and three patients scheduled every 30 minutes. The Complainant further reported that PT 2, a PT then employed at Practice A, told the Complainant to change the times that Medicare patients were scheduled so that their treatment times did not overlap even though multiple Medicare patients were treated at the same time.[4]

5. The Complainant explained to PT 2, who had been practicing in the United States for only two months, that he could get into trouble for changing the scheduled treatment times for Medicare patients.

6. The Complainant suggested to the Respondent and to the other co-owner, PT 3, an alternative way to schedule Medicare patients so they would not be double-booked. Although PT 3 told the Complainant that she had a good idea, the Complainant later noticed that Medicare patients were once again "double-booked."[5]

7. In or around June 2015, the Complainant resigned from her employment at Practice A.

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[3] The Complainant submitted to the Board a written complaint on June 25, 2015.
[4] The Board has separately charged PT 1 with violations of the Act (Board Case # 15-67B).
[T] The Board has separately charged PT 3 with violations of the Act (Board Case # PT 15-50 and PT 15-67).

8. The Board thereafter initiated an investigation of the Complainant's complaint that included: conducting under-oath interviews with the Respondent, PT 1 and PT 3; obtaining by subpoena from Practice A patient schedules[6] and treatment records of ten randomly selected Medicare patients[7] and transmitting the investigative material to a PT expert (the "Expert") for review.

9. Review of patient charts revealed many instances where the objective portions of notes were identically worded for several visits. When interviewed under oath, co-owner PT 3 told Board staff that progress notes and re-evaluations are "populated" from previous notes and re-evaluations. PT 3 further stated, "it will have been *(sic)* better if we went up and changed the observation, but I believe that we are more focused on the tests that were done...the test scores were different. [The note] wasn't the same."

10. Review of the patient schedules confirmed that on several instances, as many as four to six patients were schedule in a single hour in an office at which only one PT treated patients.

11. When interviewed under oath by Board staff, PT 1, whom the Respondent and co-owner PT 3 identified as the Director of PT at Practice A, stated that there was no scheduling policy at Practice A and characterized scheduling of patients as "chaos." PT 1 explained that Practice A offered free transportation to patients and that often more than three patients an hour were transported to the office for treatment. PT 1 stated that when she had discussed the scheduling issue with

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[6] The Board requested the patient schedule for the period from April 1, 2015 to April 30, 2015 from the Baltimore office and for the period from April 1, 2015 to May 31, 2015 from the Catonsville office.

[7] Of the ten patients whose records were subpoenaed, all but three (Patients 7, 8 and 10) had been discharged from Practice A prior to the date of the subpoena.

the Respondent and PT 3 she had been told that a second driver would be hired to alleviate the problem, but that did not happen while she was employed.

II. Findings of the Expert

12. The Respondent provided physical therapy services to Patients 1, 4, 8 and 10.

13. Upon review of the records, the Expert found that the Respondent generally failed to meet standards of practice and/or documentation as follows:

    a. The Respondent consistently failed to document objective findings and measures, including details of functional testing. Notes documented by the Respondent and other PTs at Practice A typically list only treatment provided in the objective portion of the note; the notes lack parameters or objective measures upon which treatment is based;

    b. The Respondent consistently billed for multiple, timed, one-on-one procedure codes such as therapeutic procedure in the absence of supporting documentation;

    c. The Respondent consistently failed to include exercise flow sheets and home exercise programs in patients' charts;

    d. The Respondent failed to document patient appointment cancellations and no-shows;

    e. The Respondent consistently billed using two or more codes for each date of visit. Such billing is permitted under Medicare regulations as long as sufficient evidence to support the billing level is documented. The Respondent failed to document that the therapeutic procedures were performed with appropriate evaluation to support the manual therapy code

or were of a level of skill sufficiently significant to require billing as a therapeutic procedure that requires one-on-one presence;

f. The Respondent consistently failed to consider a patient's lack of progress or failure to attain treatment goals within a reasonable amount of time and to adapt treatment plans and goals accordingly.

14. In addition to the general standards of practice and documentation deficiencies noted in ¶ 15, the Expert found the following patient-specific deficiencies as set forth below.

Patient 1

15. Patient 1 was a 77-year-old female whose diagnoses include: knee contusion; pain in lower leg joint; genu valgum[8] and abnormality of gait. She was seen at Practice A from March 17, 2015 for a total 20 visits and was discharged on May 14, 2015. The Respondent saw Patient 1 only once, on her first visit when he conducted Patient 1's initial evaluation. In his notes of the initial evaluation, the Respondent documented that Patient 1 uses an assistive device, but failed to identify the type of device. The Respondent documented nearly identical prior levels of function and current functional limitations, thereby making it difficult to determine Patient 1's functional needs at the time of evaluation. The recorded muscle strength deficit would manifest itself in observable gait deviation; however the Respondent failed to evaluation Patient 1's gait. The Respondent documented in Patient 1's chart that the Respondent provided manual therapy but failed to evaluate joint or soft tissue mobility.

[8] The term for knock-knee.

Patient 4

16. Patient 4 is a 69-year-old female with generalized muscle weakness and balance deficits. Patient 4 was seen at Practice A from October 20, 2014 for a total of 36 visits and was discharged on May 21, 2015.

17. The Respondent's initials appear on the patient billing statement for the date of the October 20, 2014 initial evaluation; however, the evaluation is documented by a PT other than the Respondent.

Patient 8

18. Patient 8 is a 70-year-old male with diagnoses including pain in his lower leg, chronic pain syndrome and difficulty walking. Patient 8 was seen at Practice A from April 30, 2015 for a total of 31 visits, and was discharged on August 4, 2015. The Respondent documented treatment notes on June 23, 2015 and July 7, 2015, Patient 8's 19th and 23rd visits, respectively.

19. The Respondent's notes are worded identically and most components are identical to prior notes written by a PT other than the Respondent. In addition, the notes appear consecutively in Patient 8's record, not in date sequence, indicating that the earlier note was not written contemporaneously with the visit.

20. The Respondent failed to recognize or consider that Patient 8 failed to attain treatment goals within a reasonable period of time; the Respondent failed to make changes to the treatment plan or goals. The Respondent billed for two units of manual therapy on both treatment dates in the absence of a joint assessment/evaluation to support performance of manual therapy.

Patient 10

21. Patient 10 is a 75-year-old female whose diagnoses include: gait abnormality; joint pain; lower leg and difficulty walking. Patient 10 was seen at Practice A from March 26, 2015 for a total of 36 visits and was discharged on July 24. 2015.

22. The Respondent treated Patient 10 on July 2, 2015, her 30th office visit. The Respondent documented that he provided mobilization techniques; however, there is no documentation in any of the notes that joint assessment/evaluation was performed, nor did the Respondent document that he had done so.

23. The Respondent billed the use of a bike for range of motion as a timed therapeutic procedure in the absence of documentation of the need for this exercise to be considered as a one-on-one therapeutic procedure.

24. The Respondent failed to consider Patient 10's lack of treatment goal achievement and failed to evaluate or adapt her treatment plan and goals.

The Respondent's Remedial Plan

25. The Respondent acknowledges the deficiencies noted by the Expert and has advised that he and PT 3 are implementing remedial changes to the practice's scheduling and billing issues, including the regular audit of patient charts by a compliance manager.

CONCLUSIONS OF LAW

The Respondent's conduct, in whole or in part, constitutes violations of the Act, specifically, Health Occ. § 13-316 (12), (14), (15), (19), (20) and (25) and the Board's regulations under which the Respondent was charged. The Board dismisses the

charge that the Respondent willfully and without legal justification failed to cooperate with a lawful investigation conducted by the Board (Health Occ. § 13-316(24).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 9TH day of May, 2017, by a majority of the quorum of the Board:

ORDERED that the Respondent is reprimanded; and it is further

ORDERED that the Respondent shall be placed on probation for a minimum of two (2) years and until the Respondent complies fully with the following terms and conditions:

a. Within the first ninety days (90) days of probation, the Respondent shall successfully pass the Board's closed-book law examination with a passing score of 90 percent;

b. Within the first three months of probation, the Respondent at his own expense, he shall successfully complete three separate Board-approved courses: 1) documentation; 2) billing and 3) professional ethics. The Respondent shall submit documentation to the Board of his completion of each course in a timely manner. The courses are not to be credited toward the continuing education credits required for licensure renewal;

c. On a quarterly basis, the Respondent shall transmit to a Board-approved expert ("Expert") ten (10) patient charts for review of compliance with standards of practice;

d. The Respondent shall ensure that the Expert provide to the Board quarterly reports of the Expert's review in a timely manner; and it is further

ORDERED that within the first six (6) months of probation, the Respondent shall pay a fine of $5,000 to be paid in full to the Board by certified check or bank guaranteed check made payable to the Maryland State Board of Physical Therapy Examiners; and it is further

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

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

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

ORDERED that for purposes of public disclosure, as permitted by Md. Code Ann. General Provisions Article, § 4-333(b), this document consists of the contents of the foregoing Findings of Fact, Conclusions of Law and Order and that the Board may also disclose same to any national reporting data bank to which it is mandated to report.

5/9/17
Date

Krystal Lighty, D.P.T.
Chair
Maryland Board of Physical Therapy Examiners

CONSENT

I, Ali D. Kanji, PT, acknowledge that I have had the opportunity to be represented by counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

5/1/17.
Date

Ali D. Kanji, PT
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Baltimore City

I HEREBY CERTIFY that on this 1 day of May 2017, before me, a Notary Public of the foregoing State and City/County personally appeared Ali D. Kanji, PT, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

SHANNON D. BOSWELL NOTARY PUBLIC BALTIMORE CITY, MD MY COMMISSION EXPIRES MAY 19, 2017

Notary Public

My commission expires: 05/19/2017