IN THE MATTER OF	*	**BEFORE THE STATE BOARD**
JOANNE O'NEILL, P.T. MEYERS	*	**OF PHYSICIAL THERAPY**
License No.: 15493	*	**EXAMINERS**
Respondent	*	**Case No.: 01-BP-139**

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

FINAL CONSENT ORDER

Based on information received and a subsequent investigation by the State Board of Physical Therapy Examiners (the "Board"), and subject to Md. Health Occ. Code Ann. § 13-101 *et seq.* (the "Act"), the Board charged Joanne O'Neill Meyers, P.T., ("Respondent"), with violations of the Act. Specifically, the Board charged the Respondent with violation 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, 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) Submits a false statement to collect a fee;
>
> (16) Violates any provision of this title or rule or regulation adopted by the Board;
>
> (21) Grossly overutilizes health care services;
>
> (26) Fails to meet accepted standards in delivering physical therapy care.

The Board also charged the Respondent with violations of the Code Md. Regs. tit. 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 be 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,
(k) If there is a physical therapy 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 for discharge,
(d) Recommendations for follow-up, and
(e) Signature and title.

The Board issued the charges on January 21, 2003. Thereafter, a Case Resolution Conference was held on April 3, 2003. Following the Case Resolution Conference, the parties agreed to resolve the matter by way of settlement. The parties and the Board agreed to the following:

FINDINGS OF FACT

The Board makes the following findings:

1. The Respondent is licensed to practice physical therapy in the State of Maryland. The Respondent was originally licensed on August 31, 1983.

2. At all times relevant hereto, the Respondent was employed as a physical therapist by Concentra Medical Centers, Inc. ("Concentra").

3. On or about March 11, 1999, the Board received a complaint from the Special Investigation Unit of the Injured Workers' Insurance Fund ("IWIF") that Concentra overutilized the following PT procedures, as identified by the Current Procedural Terminology ("CPT") assigned to them:

> **95831**- muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report
>
> **95851**- range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)

4. Thereafter, the Board conducted an investigation of services provided and claims submitted to IWIF by Physical Therapists ("PTs") and Physical Therapy Assistants ("PTAs") employed by Concentra at the time the complaint was filed. The investigation revealed documentation and coding deficiencies in addition to those originally alleged in the IWIF complaint.

CPT CODES

5. CPT codes provide a uniform language that accurately describes medical, surgical and diagnostic procedures. According to the CPT Manual, the CPT is "the most widely accepted nomenclature for the reporting of physician procedures and service under government and private health insurance programs. CPT is also useful for administrative management purposes such as claims processing and for the development of guidelines for medical care review."

a. Codes 95831 and 95851

6. The CPT codes identified in the IWIF complaint, 95831 and 95851, are classified as Neurology and Neuromuscular Procedures.[1] Both codes are appropriate to evaluate a patient who has suffered deficiencies as a result of a neurological disorder or disease such as stroke or multiple sclerosis in order to document the patient's progression or regression. Both of these codes require the physical therapist to generate a separate report.

7. The term "separate procedure," as used in the description of the codes in the CPT manual, identifies a procedure that is commonly carried out as an integral component of a total service or procedure. The CPT manual states further:

> The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component. However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or

[1] The most common CPT codes recorded in Concentra patient records are listed in the Physical Medicine and Rehabilitation section, the first two digits are "97." Unless a four-digit CPT code suffix is specified, the suffix for all codes used herein is "0000."

distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending the modifier "-59" to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).

8. Code 95831 is defined in the CPT manual as follows: Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report.

9. Code 95851 is defined in the CPT manual as follows: Range of motion ("ROM") measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine).

10. Objective findings such as muscle strength and range of motion are a standard of physical therapy documentation and are to be performed once a week at a minimum. It is not standard physical therapy practice to bill separately for these measurements except when being performed as re-evaluation. It is standard physical therapy practice to assess and interpret objective findings that result from muscle testing and range of motion testing in order to determine whether changes should be made to the patient's treatment plan and/or goals.

b. Code 97110-Therapeutic exercise

11. Therapeutic exercise (CPT code 97110) is classified as a therapeutic procedure. A therapeutic procedure is "a manner of effecting change through the application of clinical skills and/or services that attempt to improve

function. Physician or therapist required to have direct (one on one) patient contact."

12. Therapeutic exercise is defined in the CPT manual as follows: Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion and flexibility.

13. Instructing a patient how to perform the exercise is a component of a therapeutic exercise and is not to be billed as a separate charge by the provider.

c. Code 97112- Neuromuscular re-education

14. Neuromuscular re-education (Code 97112) is classified as a therapeutic procedure and incorporates all of the elements of therapeutic exercises. Neuromuscular re-education is further defined as the neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and proprioception.

d. Code 97530- Therapeutic activity

15. Therapeutic activity (Code 97530) is classified as a therapeutic procedure and is defined as, "direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes."

General Allegations of Deficiencies

16. Throughout the patients' treatment records, the Respondent noted and billed for therapeutic exercises and therapeutic activities in the absence of documentation that the patients required one-on-one supervision, contact or instruction during these activities.

17. Treatment plans as written in initial evaluations are inadequate in that they lack treatment procedures and/or modalities to be provided.

18. CPT codes are used for tests conducted shortly after a patient's initial evaluation. These tests include: range of motion, manual muscle testing, reflexes, girth and grip strength. Objective findings are a standard of physical therapy documentation and are to be performed on a weekly basis at minimum. It is not standard practice to bill separately for these measurements, except as part of a re-evaluation. The Respondent failed on most occasions to prepare reports for those procedures that are defined in the CPT manual as a "separate procedure" but billed for the procedure nonetheless.

Patient-Specific Allegations

Patient A

20. Patient A, a female born in 1939, initially presented to Concentra on June 15, 1998 after falling on her hands and knees in a work-related accident. She was evaluated by a Concentra physician on that date, diagnosed with multiple contusions and referred to physical therapy.

21. The Respondent treated Patient A on June 15, 1998. The Respondent's treatment plan is not adequate as it notes only, "Cont." In addition, the Respondent noted A[ctivities of] D[aily] L[iving] as the initial treatment; however, she failed to document any loss or disruption of Patient A's ADLs or functional activities.

22. The Respondent treated Patient A on June 17, 1998 and noted the following charges for that visit: Procedures - Therapeutic Exercise (97110) and

Therapeutic Activity (97530); and Tests - Range of Motion (95851) and Girth Measurements (97799)[2].

23. The Respondent's documentation of the June 17, 1998 visit fails to support charging under the test codes. The Respondent also failed to prepare a discharge summary although Patient A was discharged from physical therapy on that date.

Patient B

24. Patient B, a female born in 1947, initially presented to Concentra on December 11, 1998 complaining of a contusion to her right forearm.

25. The Respondent evaluated Patient B on December 11, 1998. The Respondent's treatment plan is insufficient as it states merely, "Cont." In addition, the Respondent's initial treatment included ADLs, although she failed to document that Patient B had sustained a loss or disruption to her ADLs or functional activities.

26. The Respondent treated Patient B on December 14, 1998 and noted the following charges: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530); and Tests - Manual Muscle Testing (95831), Range of Motion (95851) and Jamar 1 (97750).

27. The Respondent's documentation of the December 14, 1998 visit is inadequate; her documentation of objective findings is minimal and she failed to prepare a separate report for the tests for which she charged. In addition, her documentation fails to support charging under the Therapeutic Activity code.

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[2] Charges under the "Supplies" category are not at issue in this case and are not set forth herein.

28. The Respondent treated Patient B on December 30, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110); and Tests - Manual Muscle Testing (95831), Range of Motion (95851), Girth Measurements (97799) and Jamar 1 (97750).

29. The Respondent's documentation fails to support charging under the Test codes.

30. The Respondent treated Patient B on January 4, 1999 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530); and Tests - Range of Motion (95851) and Jamar 1 (97750).

31. The Respondent's documentation of the January 4, 1999 visit does not support charging under the Test codes. In addition, the Respondent failed to document Therapeutic Activities.

32. The Respondent treated Patient B on January 6, 1999 and January 8, 1999 and noted the following charges for both visits: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530).

33. The Respondent's documentation fails to support charging under the Therapeutic Activity code for either visit as the Respondent failed to note any Therapeutic Activities.

34. The Respondent treated Patient B on January 11, 1999 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and

Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530); and Tests - Manual Muscle Testing (95831), Range of Motion (95851) and Jamar 1 (97750).

35. The Respondent's documentation fails to support charging under the Test codes. In addition, the Respondent's documentation fails to support charging under the Therapeutic Activity code because the Respondent failed to document any Therapeutic Activities.

36. The Respondent treated Patient B on March 22, 1999 and noted the following charges: Tests - Range of Motion (95851) and Jamar 1 (97750). The Respondent discharged Patient B from treatment on that date.

37. The Respondent's documentation fails to support charging under the Test codes.

Patient C

38. Patient C, a female born in 1959, initially presented to Concentra on December 7, 1998 complaining of contusions to her right leg sustained in a work-related incident.

39. The Respondent evaluated Patient C on December 7, 1998; however, she failed to document a treatment plan. The Respondent documented that initial treatment included ultrasound, cold pack and ADLs but failed to document that Patient C had suffered loss or disruption of her ADLs or functional activities.

40. The Respondent treated Patient C on December 8, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Activity (97530).

41. The Respondent's documentation of the December 8, 1998 visit fails to support charging under the Therapeutic Activity code because the Respondent failed to document that Patient C performed any Therapeutic Activities.

42. The Respondent treated Patient C on December 9, 1998, and noted the following charges for that visit: Evaluation - PT Re-Evaluation-Established Patient (97799-0006); Modalities - Hot/Cold Packs (97010) and Ultrasound (97035); Procedures - Therapeutic Activity (97530).

43. The Respondent's documentation fails to support charging under the Therapeutic Activity code as the Respondent failed to document that Patient C performed any Therapeutic Activities. In addition, the Respondent's documentation fails to support charging for a re-evaluation of this patient.

44. The Respondent treated Patient C on December 29, 1998 and noted the following charges for that visit: Tests - Manual Muscle Testing (95831), Range of Motion (95851) and Girth Measurements (97799).

45. The Respondent's documentation of the December 29, 1998 visit fails to support charging under the Test codes.

46. The Respondent treated Patient C on December 31, 1999 and noted the following charges for that visit: Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530).

47. The Respondent's documentation of the December 31, 1998 visit fails to support charging for two (2) units of Therapeutic Activity; the Respondent failed to document that Patient C had performed any Therapeutic Activities.

Patient D

48. Patient D, a female born in 1953, initially presented to Concentra on August 24, 1998 after injuring her right arm in a work-related incident.

49. The Respondent treated Patient D on August 25, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041). The Respondent also charged for ADL training (97540).

50. The Respondent's documentation of the August 25, 1998 visit fails to support charging under the ADL code as the Respondent failed to document that Patient D had sustained any loss or disruption of her ADLs or functional activities.

51. The Respondent treated Patient D on August 26, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530).

52. The Respondent's documentation of the August 26, 1998 visit fails to support charging under the Therapeutic Activity code as no Therapeutic Activities are noted. In addition, the Respondent's documentation fails to support charging for two (2) units of Therapeutic Exercise.

53. The Respondent treated Patient D on September 1, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) and Tests - Range of Motion (95851) and Jamar 1 (97750).

54. The Respondent's documentation of the September 1, 1998 visit fails to support charging under the Test codes or for Therapeutic Exercise.

55. The Respondent treated Patient D on September 2, 1998 and September 4, 1998 and noted the following charges for both visits: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530).

56. The Respondent's documentation of the September 2 and September 4, 1998 visits fail to support charging under the Therapeutic Activity code as no Therapeutic Activities were noted. In addition, the documentation fails to support charging for two (2) units of Therapeutic Exercise.

57. The Respondent treated Patient D on September 9 and September 14, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530). On September 9, 1998 she charged for Range of Motion test (95851); on September 14, 1998, she charged for Jamar 1 test (97750).

58. The Respondent's documentation of the September 9 and September 14, 1998 visits fail to support charging under the Therapeutic Activity code as no Therapeutic Activities were noted. In addition, the documentation

fails to support charging for two (2) units of Therapeutic Exercise or under the Test codes.

59. The Respondent treated Patient D on September 23, 1998 and noted the following charges: Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530) and Tests - Jamar 1 (97750).

60. The Respondent's documentation of the September 23, 1998 visit fails to support charging under the Therapeutic Activity code as no Therapeutic Activities were noted. In addition, the Respondent's documentation fails to support charging under the Test code.

61. The Respondent treated Patient D on September 28, 1998 - the patient's last visit for treatment. The Respondent failed to complete a discharge summary.

Patient E

62. Patient E, a male born in 1956, initially presented to Concentra on August 11, 1998 after sustaining a work-related injury to his shoulder and neck.

63. The Respondent evaluated and treated Patient E on August 11, 1998 and noted the following charges: Evaluation - PT Evaluation New Patient II (97799-0004); Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); and Procedures - Therapeutic Exercise (97110).

64. The Respondent's documentation of the evaluation is inadequate because he failed to document a treatment plan.

65. The Respondent treated Patient E on August 12, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical

Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530); and Tests - Range of Motion (95851).

66. The Respondent's documentation of the August 12, 1998 visit fails to support charging for two (2) units of Therapeutic Exercise, nor does it support charging under the Therapeutic Activity code as no Therapeutic Activities are documented. The Respondent's documentation also fails to support charging under the Test code.

67. The Respondent treated Patient E on August 13, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530).

68. The Respondent's documentation of the August 13, 1998 visit fails to support charging for two (2) units of Therapeutic Exercise, nor does it support charging under the Therapeutic Activity code.

69. The Respondent treated Patient E on August 17, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units), Neuromuscular Re-education (97112) and Therapeutic Activity (97530); and Tests - Range of Motion (95851).

70. The Respondent's documentation of the August 17, 1998 visit fails to support charging under the test code or for two (2) units of Therapeutic Exercise. Moreover, the Respondent failed to document that any Neuromuscular Re-education was performed.

71. The Respondent treated Patient E on August 18, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Electrical Stimulation (97041) (2 units), Neuromuscular Re-education (97112) and Therapeutic Activity (97530).

72. The Respondent's documentation of the August 18, 1998 visit fails to support charging for two (2) units of Therapeutic Exercise. Moreover, the Respondent failed to document that any Neuromuscular Re-education was performed.

73. The Respondent treated Patient E on August 20, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units) and Tests - Range of Motion (95851).

74. The Respondent's documentation of the August 20, 1998 visit fails to support charging under the Test code.

75. The Respondent treated Patient E on August 21, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530).

76. The Respondent's documentation of the August 21, 1998 visit fails to support charging for two (2) units of Therapeutic Exercise.

77. The Respondent treated Patient E on August 24, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical

Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530); and Tests - Range of Motion (95851).

78. The Respondent's documentation fails to support charging for two (2) units of Therapeutic Exercise, nor does it support charging under the Test code.

Patient F

79. Patient F, a female born in 1965, initially presented to Concentra on October 8, 1998 after sustaining an injury to her shoulder in a work-related incident. Patient F was referred to physical therapy by a Concentra physician.

80. A PT other than the Respondent treated Patient F on October 9, 1998. The treatment plan included modalities and procedures to achieve goals.

81. The Respondent treated Patient F on October 13, 1998 and noted the following charges: Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530).

82. The Respondent's documentation of the October 13, 1998 visit fails to support charging under the Therapeutic Activity code as no Therapeutic Activities are noted.

83. The Respondent treated Patient F on October 14, 1998 and noted the following charges: Procedures: Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530).

84. The Respondent's documentation of the October 14, 1998 visit fails to support charging under the Therapeutic Activity code as no Therapeutic Activities are noted.

85. The Respondent treated Patient F on October 15, 1998 and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110)(2 units) and Therapeutic Activity (97530); and Tests - Range of Motion (95851).

86. Although the Respondent's documentation of the October 15, 1998 visit minimally supports charging for two (2) units of Therapeutic Exercise, it fails to support charging under the Test code. The Respondent failed to complete a discharge summary despite the fact that this was Patient F's last treatment for this injury.

Patient G

87. Patient G, a male born in 1958, initially presented to Concentra on September 4, 1998 with a knee injury he sustained at work.

88. The Respondent evaluated Patient G on September 4, 1998 and failed to note a treatment plan other than, "Cont." The Respondent also failed to note in her evaluation Patient G's functional activity needs required of his employment setting.

89. The Respondent treated Patient G on September 8, 1998 and noted the following charges: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530); and Tests - Range of Motion (95851) and Girth Measurements (97799).

90. The Respondent's documentation of the September 8, 1998 visit fails to support charging under the Therapeutic Activity code because no

Therapeutic Activities are noted. In addition, the documentation fails to support charging under the Test code.

91. The Respondent treated Patient G on September 9, 1998 and noted the following charges: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530).

92. The Respondent's documentation of the September 9, 1998 visit fails to support charging under the Therapeutic Activity code because no Therapeutic Activities are noted.

93. The Respondent treated Patient G on September 11, 1998 and noted the following charges: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530) and Tests - Range of Motion (95851).

94. The Respondent's documentation of the September 11, 1998 visit fail to support charging under the test code or under the Therapeutic Activity code as no Therapeutic Activities were noted.

95. The Respondent treated Patient G on September 14, 1998 and noted the following charges: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530).

96. The Respondent's documentation of the September 14, 1998 visit fails to support charging under the Therapeutic Activity code as no Therapeutic Activities were noted.

97. The Respondent treated Patient G on September 17, 1998 and noted the following charges for that visit: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530); and Tests - Range of Motion (95851).

98. The Respondent's documentation of the September 17, 1998 visit fails to support charging under the Test code.

99. The Respondent treated Patient G on September 21, 198 and noted the following charges for that visit: Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112) and Therapeutic Activity (97530).

100. The Respondent's documentation fails to support charging under the Neuromuscular Re-education code.

101. The Respondent treated Patient G on September 24, 1998 and noted the following charges: Evaluation - PT Re-evaluation - established patient; Procedures -Therapeutic Exercise (97110), Neuromuscular Re-education (97112) and Therapeutic Activity (97530).

102. The Respondent's documentation of the September 24, 1998 visit fails to support charging under the Therapeutic Activity code as no Therapeutic Activities were noted. In addition, the Respondent's documentation fails to support charging under the re-evaluation code.

103. The Respondent's documentation is also deficient because she failed to document objective findings in Patient G's record after September 11, 1998.

104. The Respondent was interviewed by the Board during its investigation of this case. The Respondent's explanation of the difference between Therapeutic Exercise and Therapeutic Activity does not reflect the accepted and published definition of those terms. Her statements with regard to the codes that she is alleged herein to have failed to have provided adequate

documentation likewise failed to support use of those codes. In addition, the Respondent failed to justify her failure to complete treatment plans in patient records.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board finds that the Respondent violated Md. Health Occ. Code Ann. §§ 13-316(15), (16), (21), and (26). The Board also finds that the Respondent violated Code Md. Regs. tit. 10, § 38.03.02-1.

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 30th day of MAY, 2003, by a majority of a quorum of the Board,

ORDERED that the Respondent shall be placed on probation for a period of at least one (1) year, subject to the following conditions:

1. The Respondent shall pay a fine in the amount of one thousand dollars ($1,000.00), to be paid prior to the termination of probation;

2. The Respondent shall take the Board-approved law and ethics course and pass the associated examination administered by the Board;

3. The Respondent shall successfully complete a Board-approved documentation course;

4. The Respondent shall successfully complete a Board-approved billing course;

5. The Respondent may apply the above coursework to the

Respondent's continuing education requirements for licensure renewal;

AND IT IS FURTHER ORDERED that if the Respondent fails to comply with any of the terms or conditions of probation set forth above, that failure shall be deemed a violation of this Order; 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 it is further

ORDERED that should the Board receive a report that the Respondent's practice is a threat to the public health, welfare and safety, the Board may take immediate action against the Respondent, including suspension or revocation, providing notice and an opportunity to be heard are provided to the Respondent in a reasonable time thereafter. Should the Board receive in good faith information that the Respondent has substantially violated the Act or if the Respondent violates any conditions of this Order or of Probation, after providing the Respondent with notice and an opportunity of 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 of Probation shall be upon the Respondent to demonstrate compliance with the Order or conditions; and it is further

ORDERED that the Respondent shall bear the expenses associated with the Consent Order; and it is 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 the Respondent's license, provided the Respondent can demonstrate compliance with the conditions of this Order. Should the Respondent fail to demonstrate compliance, the Board may impose additional terms and conditions of Probation, as it deems necessary; and it is further

ORDERED that for purposes of public disclosure, as permitted by Md. State Gov't Code Ann. § 10-617(h) (Repl. Vol. 1999), this document consists of the 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.

5.20.03
Date

Penelope D. Lescher, M.A., P.T., M.C.S.P., Chair
State Board of Physical Therapy Examiners

CONSENT

I, Joanne O'Neill Meyers, P.T., by affixing my signature hereto, acknowledge that:

1. I am represented by an attorney and have been advised by my attorney of the legal implication of signing this Consent Order;

2. I am aware that without my consent, my license to practice physical therapy in this State cannot be limited except pursuant to the provisions of H.O. § 13-317 and the Maryland Administrative Procedure Act, codified at State Gov't §§ 10-219 *et seq.*

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

4. By this Consent Order, I hereby consent and submit to the foregoing Findings of Fact, Conclusions of Law and Order, provided the Board adopts the foregoing Consent Order in its entirety. 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 behalf and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the 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.

5. I acknowledge that failing to abide by the condition set forth in this Order, I may, after an opportunity to be heard, suffer disciplinary action, including revocation of my license to practice physical therapy in the State of Maryland.

6. While I have consented and submitted to the foregoing Findings of Fact, Conclusions of Law and Order, I did not intentionally, knowingly or willfully submit a false statement to collect a fee.

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

5-16-03
Date

Joanne O'Neill - Meyers PT
Joanne O'Neill Meyers, P.T.
Respondent

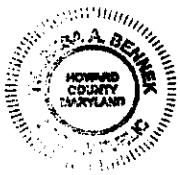
STATE OF: MARYLAND

CITY/COUNTY OF: HOWARD

I HEREBY CERTIFY that on this 16 day of MAY, 2003, before me, a Notary of the State of MARYLAND and the City/County of HOWARD, personally appeared Joanne O'Neill Meyers, P.T., and made oath in due form of law that signing the foregoing Consent Order was his/her voluntary act and deed, and that the statements made herein are true and correct.

AS WITNESS my hand and notarial seal.

Theresa A. Bennek
Notary



Theresa A. Bennek, Notary Public
Howard County
State of Maryland
My Commission Expires July 1, 2003

My Commission expires: 7-1-03