IN THE MATTER OF	*	**BEFORE THE**
RAYMOND SCHMIDT, JR., L.Ac., P.T.	*	**MARYLAND BOARD OF**
Respondent	*	**PHYSICAL THERAPY EXAMINERS**
License Number: 17413	*	**Case Numbers: 02-9 & 02-15**

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CONSENT ORDER

The Maryland Board of Physical Therapy Examiners (the "Board"), on November 7, 2003 voted to charge Raymond Schmidt, Jr., L.Ac., P.T., (the "Respondent") (D.O.B. 04/06/35), License Number 17413, under the Maryland Physical Therapy Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§13-301 *et seq.* (2000). On February 17, 2004, the Board issued Amended Charges.

The pertinent provisions of § 13-316 provide:

> (a) 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 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;
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> (16) Violates any provision of the title or rule or regulations adopted by the Board;
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> (26) Fails to meet accepted standards in delivering physical therapy care;

In addition, the Board charged Respondent with violations of the Code of Ethics, COMAR 10.38.03.02-1[1], which state in pertinent part:

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[1] The Board's regulations regarding requirements for documentation were last revised in January 2003. The regulations under which Respondent is being charged are the regulations that were in effect at the time of the treatments.

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;

COMAR 10.38.02.01 Code of Ethics

B. The physical therapist and the physical therapist assistant shall respect the dignity of the patient;

COMAR 10.38.02.02 Sexual Misconduct

B. Sexual misconduct includes, but is not limited to:

2. Sexual behavior with a client or patient under the pretext of diagnostic or therapeutic intent or benefit;

6. A verbal comment of a sexual nature;

8. Discussion of unnecessary sexual matters while treating a patient;

11. An unnecessary sensual act or comment.

Respondent was notified of the charges through service by certified mail on November 7, 2003. Respondent's counsel was notified of the amended charges by regular mail on February 17, 2004. A hearing was scheduled for this matter before the Board and the Board of Acupuncture for Thursday, April 8, 2004.

On January 6, 2004, Respondent, his attorney Lois A. Fenner McBride, Esquire, and Janet Klein Brown, Administrative Prosecutor, appeared before the Case Resolution Conference Committee (the "CRC") of the Board. As a result of negotiations with the CRC, Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law and Order, with the terms and conditions set forth below.

FINDINGS OF FACT

1. At all times relevant to these charges, Respondent was and is licensed to practice physical therapy in the State of Maryland.

2. Respondent was originally issued a license to practice physical therapy in Maryland on December 18, 1992, being issued license number 17413. Respondent renewed his physical therapist's license in May 2003, which will expire in May 2005.

3. Respondent is also licensed to practice acupuncture in the State of Maryland. Respondent was originally issued a license to practice acupuncture in Maryland on January 11, 2000, being issued license number U941. Respondent renewed his acupuncture license in May 2003, which will expire in May 2005.

4. At all times relevant to these charges, Respondent maintained a private practice in Pasadena, Maryland, practicing under the name of "Chesapeake Therapy Center" and "Arts & Sciences of Health." Respondent's private practice focused on holistic treatment using both acupuncture and physical therapy procedures.[2]

5. On October 16, 2001, the Board of Physical Therapy received a complaint from a patient, Patient A[3], regarding an "acupuncturist" whom she identified as also being licensed as a physical therapist. Patient A stated in her complaint that on October 2, 2001, she was the victim of sexual harassment by Respondent.[4]

6. Thereafter, the Board initiated an investigation of the complaint.

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[2] Respondent also worked in a hospital setting as a physical therapist. However, all violations referenced herein occurred while Respondent was practicing in his private practice setting.

[3] To ensure confidentiality, the patient names are not used in this Consent Order. The Respondent is aware of the identity of the patients as referred to in these charges.

[4] Patient A sent the identical complaint to the Board of Acupuncture.

7. On January 18, 2002, during the investigation, another patient, Patient B, filed a complaint, stating that Respondent had treated her for pain related to psoriatic arthritis in her shoulder, that he exposed her bare breasts and asked her questions about orgasms and sexual activities.[5]

8. During the investigation, review of Respondent's treatment records of seven (7) patients revealed failure to meet accepted standards in delivering physical therapy care, failure to meet requirements for documentation, and submission of false statements to collect a fee, as stated below.

I. **Findings Regarding Failure to Meet Accepted Standards in Delivering Physical Therapy Care, Failure to Respect the Dignity of the Patient, and Discussion of Unnecessary Sexual Matters While Treating a Patient.**

Patient A

9. On October 2, 2001, Patient A (d.o.b. 5/09/73), then a 28 year old female registered nurse, on referral from a friend, sought treatment from Respondent for chronic headaches, which began 6 months prior to the beginning of her pregnancy and continued thereafter.

10. Patient A completed a social/health questionnaire Outpatient Form, which indicated, among other things, "depression, taking Prozac, Tylenol #3 for headaches, had headaches as a child, recent MRI of head and sinus." Patient A's chief complaint was "severe constant headaches during pregnancy since May 2001."

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[5] The Board sent a copy of Patient B's complaint to the Board of Acupuncture.

11. Respondent relied upon his training and licensure as an acupuncturist to ask Patient A several sexually explicit questions during her intake and treatment.[6] In response to Patient A's asking why he had not written down her answers to his questions, Respondent stated, "I was just curious about that stuff... I love my job. Now when I see you in the hospital I can yell, 'hey H----- have you masturbated yet today?'"

12. As part of the Respondent's standard treatment protocol, Respondent instructed Patient A to undress to her underwear. When Patient A inquired whether she should remove her bra, he told her to do so. Respondent did not provide Patient A with a gown but provided a drape.

13. Respondent rubbed and touched Patient A's legs and stated she had "good muscle tone." Respondent pulled on Patient A's ankles and told her that one leg was longer than the other and it could "cause headaches."

14. Respondent told Patient A that he was going to pull down the drape covering her chest and abdomen and look for "symmetry." Responded removed the drape covering Patient A, exposing her breasts. He put his hands on her stomach, rib cage, hips, and then on her pelvic bone. Patient A has a tattoo above the pubic area that was partially exposed. Respondent pulled on Patient A's underwear to expose the tattoo and said "oh what a nice surprise... I like that." Respondent pulled up his sleeve and showed Patient A that he had a tattoo on his arm. Respondent then pulled the drape back up and then put his hand on her abdomen, rib cage and chest to feel for "blood flow."

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[6] As a physical therapist, Respondent would have been permitted to ask questions of a sexual nature only if they were related to the patient's identified injury or diagnosis.

15. Respondent massaged Patient A's temples and scalp and inserted acupuncture needles on both sides of her neck and shoulders.

16. Respondent documented in the treatment record "decreased sex secondary to headaches, no problem orgasming, occasional masturbation."

17. Patient A denies having any problems with her sexual health.

18. After the examination/treatment, while Patient A was in the reception area writing her check, Respondent spontaneously hugged her.

19. Patient A informed her husband, her mother-in-law, and a friend regarding her discomfort with her treatment by Respondent.

20. Respondent told Patient A to call for a follow-up appointment. Patient A did not call. Respondent called Patient A. Patient A was uncomfortable with the initial appointment and did not want to return so she told Respondent she could not afford the treatment.

21. Patient A did not return for further treatment by Respondent.

Patient B

26. Patient B[7] (d.o.b. 10/27/74), then a 27 year old female licensed physical therapist, specializing in pediatrics, presented to Respondent on March 13, 2001 with complaints of chronic pain related to psoriatic arthritis, which seemed to remit during pregnancies. Patient B, who was self-referred, requested homeopathic pain management while breastfeeding, having recently delivered a baby.

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[7] Patient B is one of 40 patients on a list of female patients that Respondent provided in response to a subpoena from the Board requesting a list of all females treated from October 2000 to October 2001. The investigator randomly called Patient B and after the interview, she filed a written complaint with the Board.

27. A Preface Sheet completed by Respondent, indicated, among other things, "right-sided excruciating pain," but Respondent did not specify the location, and "good libido."

28. Pursuant to Respondent's standard treatment procedure, on Patient B's first visit, Respondent instructed her to undress to her underpants and provided her with a drape. During the physical examination, when palpating Patient B's ribs, Respondent asked, "Do you mind if I have a look?" Respondent lowered the drape to her waist exposing her bare breasts. Patient B's breasts were engorged due to breastfeeding. Patient B informed Respondent regarding her discomfort about the appearance of her breasts. Respondent said, "Oh they are beautiful." Respondent then covered her up with the drape.

29. Respondent told Patient B, who is blonde, about another patient and how flattered he was that a beautiful young blonde patient threw herself at him, that he felt her "sexual meridian" fluttering, and he was flattered that she was very attracted to him.

30. Respondent performed acupuncture on a point on Patient B's shoulder and performed some physical therapy including manual adjustment of the clavicle and muscle re-education.

31. Patient B stated that the treatment in the spring was very successful and when she again began experiencing clavicle pain, she reluctantly returned to Respondent on November 28, 2001.

32. Relying on Respondent's holistic training and licensure as an acupuncturist, Respondent asked her "do you have orgasms every time you and your husband have sex or does he have to do special things?" Patient B asked Respondent

why he asked her those questions. Respondent replied, "When you're feeling really bad you're not in the mood, you can't get into sex."

33. Again during the treatment, Respondent exposed Patient B's breasts.

34. Respondent repeated the information about the patient who "threw herself at him" and also told Patient B about another patient who came to him for treatment because her libido was poor and "she was all over me."

35. At the November appointment, Respondent commented on Patient B's weight loss by stating "hey skinny."[6] When Respondent removed the drape, exposing her breasts, he made the observation "wow your ribs are out of whack."

36. Patient B did not return for further treatment by Respondent.

37. Patient B informed her husband regarding her experiences with Respondent.

Patients A and B:

38. Respondent failed to meet accepted standards in delivering physical therapy care and violated the Code of Ethics by failing to respect the dignity of Patients A and B and engaged in sexual misconduct while treating Patients A and B in that he:

a. Made verbal comments of a sexual nature to patients;

b. Discussed unnecessary sexual matters while treating patients by telling them about other patients who are sexually interested in him;

c. Discussed irrelevant personal and intimate details of sexual matters regarding other patients with his patients;

[6] Patient B had lost a lot of weight since the spring appointments.

d. Made unnecessary sensual comments to patients;

e. Disclosed to patients his personal feelings regarding the patients; and

f. Failed to recognize the impact of his comments on his female patients.

39. Although physical therapists are not permitted to ask sexually explicit questions of their patients unless directly related to an identified diagnosis or injury, Respondent relied on his holistic training and licensure as an acupuncturist to:

a. Ask patients detailed intimate questions about their sexual activities during his patient intake; and

b. Discuss sexual matters while treating patients by asking detailed intimate questions about their sexual activities.

40. Without adequately informing patients about the Respondent's holistic approach to treatment and his standard procedure to request that patients completely disrobe, Respondent:

a. Asked female patients to undress down to their underpants when it was not directly related to the patients' presenting problems and diagnoses; and

b. Exposed female patients' breasts when it was not directly related to the patients' presenting problems and diagnoses.

II. Findings Regarding Failure to Meet Accepted Standards in Delivering Physical Therapy Care, Failure to Meet Requirements for Documentation, and Submits a False Statement to Collect a Fee.

Patient A

41. On the October 2, 2001 visit, Patient A completed a social/health questionnaire Outpatient Form, which indicated, among other things, depression, taking Prozac, Tylenol #3 for headaches, had headaches as a child, recent MRI of head and sinus. Patient A's chief complaint was "severe constant headaches during pregnancy since May 2001."

42. A Preface Sheet, completed by Respondent, indicated, among other things, "chronic daily severe maxillary headaches, pain 8 out 10, currently six months pregnant, decreased sex secondary to headaches, no problem orgasming, occasional masturbation; Appetite: ravenous/no problems/craving salt, sweets, anorexic."

43. Respondent did not inquire regarding the headaches.

44. Respondent documented a "structural exam" of Patient A, on an acupuncture form, as "Subclavicular R Pec (pectoralis muscle) major TOP (?) and occipital shear" and neck and shoulder rotation WNL.

45. Respondent did not assess the status of the muscle, presence of trigger points, the degree of rotation, flexion/extension, side banding, or assess the mobility of the vertebrae.

46. Respondent did not document performance of a physical therapy evaluation of Patient A. Respondent did not obtain any measurements or repeatable objective tests.

47. Respondent's "Traditional Diagnosis"[9] of Patient A was "migraine." Respondent did not assess the kind of migraine headache.

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[9] Traditional Diagnosis is a term used in five element Acupuncture; however, migraine is not a traditional diagnosis in Chinese medicine.

48. Respondent documented right leg length discrepancy and good muscle definition.

49. Respondent did not document whether the right leg was longer or shorter, did not assess the amount of the discrepancy, did not determine whether the discrepancy was true or false, did not specify which muscle he was assessing, and did not assess muscle strength and mass.

50. Respondent documented that he performed acupuncture, inserting a needle in the sub-occipital region. Respondent documented he performed a leg length correction, cranial sacral treatment, manual therapy and myofascial release in the cervical area.

51. Respondent did not specify the muscle on which he performed the myofascial release and did not specify the kind of correction he performed with the manual therapy.

52. Respondent billed Patient A for manual therapy, myofascial release, and acupuncture treatments for a total of $100, using ICD-9 codes for Migraine Headache and Cervical Dysfunction.

53. Respondent's bill did not use the ICD-9 code for a New Office Visit to reflect the nature of the office visit.

54. Respondent failed to meet accepted standards in delivering physical therapy care, failed to meet the requirements for documentation, and submitted a false statement to collect a fee in regard to Patient A in that he:

a. Failed to do a full PT evaluation or obtain measurable and objective data, the evaluation is minimally related to physical therapy, and most all of the evaluation is acupuncture related;

b. Failed to do a detailed ROM of cervical spine, segmental evaluation, or objective tests, to support a diagnosis of cervical dysfunction;

c. Performed physical therapy treatment without sufficient documented information to provide a rationale for the physical therapy treatment; and

d. Failed to accurately reflect the nature of the office visit in the bill.

Patient B

64. Patient B, a Pediatric Physical Therapist, initially presented to Respondent on March 13, 2001 with complaints of chronic right index finger pain related to psoriatic arthritis, which seemed to remit during pregnancies. Patient B, who was self-referred, requested homeopathic pain management while breastfeeding, having recently delivered a baby.

65. A Preface Sheet completed by Respondent, indicated, among other things, "right-sided excruciating pain," but Respondent did not specify the location, and "good libido."

66. Respondent documented a "structural exam" as "shoulder rotation ↓'d on R." Respondent did not document whether this pertained to external or internal rotation, the amount, and which joint was involved.

67. Respondent did not document performance of a physical therapy evaluation of Patient B. Respondent did not obtain any measurements or repeatable objective tests.

68. Respondent performed acupuncture in the area of Patient B's shoulder.

69. On March 13, 2001, the Respondent billed for NM (neuromuscular) Re-education, Manual Therapy and Myofascial Release for a total of $100, using ICD-9 diagnoses of Respondent diagnosed Cervical Dysfunction, Sacral Dysfunction, and U.E. (upper extremity) Dysfunction.

70. Patient B did not have any complaints regarding the sacral area of her back.

71. Respondent's bill did not reflect the nature of the visit or that he performed acupuncture.

72. On March 21, 2001, Patient B returned with complaints of increased pain with sugar ingestion, felt sick 3 days ago, nauseated, and decreased "yin." Respondent did not describe the location of the pain.

73. Respondent documented that he performed acupuncture, manual therapy, and myofascial release bilaterally to the upper trapezius muscle, scalene, sterno-claido mastoid, and levelor muscles.

74. Respondent did not document on which joints he performed manual therapy and why. Respondent did not document why he performed myofascial release.

75. Respondent billed Patient B for therapeutic exercise, manual therapy, and myofascial release for a total of $100, using ICD-9 codes for Cervical dysfunction, Sacral dysfunction, and L.E. (lower extremity) dysfunction.

76. Respondent did not document that he performed therapeutic exercise.

77. Respondent did not bill for acupuncture.

78. Patient B did not have complaints regarding the sacral area and there is no evidence of lower extremity dysfunction.

79. On November 28, 2001, Patient B presented with complaints of bilateral knee pain, right clavicle, right Sacral iliac pain, and left rib pain.

80. Respondent did not perform a physical therapy evaluation, documenting objective measurements or data, and specifically did not evaluate Patient B's knee or rib pain.

81. Respondent performed acupuncture, manual therapy, myofascial release bilaterally to scalenes, clavicular mobilization, splenius, and suboccipital release.

82. Respondent billed Patient B for NM Re-education, Manual Therapy and Myofascial Release for a total of $100, using ICD-9 codes for Sacral Dysfunction and Pelvic/Hip dysfunction.

83. Patient B did not have any complaints regarding her pelvis/hip.

84. Respondent failed to meet accepted standards in delivering physical therapy, failed to meet requirements for documentation, and submitted a false statement to collect a fee in regard to Patient B in that he:

a. Did not perform an initial physical therapy evaluation;

b. Did not provide sufficient documentation to support the diagnoses on March 13, 2001 of cervical dysfunction, sacral dysfunction and UE dysfunction;

c. Did not perform treatment that was consistent with Patient B's complaints;

e. Did not provide documentation to support the reason for performance of myofascial release and manual therapy on March 21, 2001;

f. Did not re-evaluate with objective PT measurements or data for the November 28, 2001 visit in that it had been eight months since last treatment;

g. Did not provide documentation to support the reason for performance of manual therapy, myofascial release, or suboccipital release on November 28, 2001;

h. Treated Patient B's upper body on November 28, 2001 but failed to treat the areas where she had pain; and

i. Failed to bill for a New Office Visit to accurately reflect the nature of the office visit, billed for therapeutic exercise that he did not perform, billed for treatment to sacral area on March 21, 2001 and pelvic/hip area on November 28, 2001 that was not provided, and failed to bill for acupuncture treatment that he performed.

Patient C

85. Respondent treated Patient C, a female, (Respondent did not document a birth date) on 30 occasions between June 13, 2000 and January 8, 2002.

86. On June 13, 2000, Patient C presented with headaches in right ear, right jaw, and right side of face, bilaterally in her temples, shoulders and neck. Patient C described the intensity of the pain as a 10 out of 10. Respondent obtained very minimal health history.

87. Respondent performed an acupuncture evaluation.

88. Respondent did not document performance of a physical therapy evaluation of Patient C. Respondent did not obtain any measurements or repeatable objective tests.

89. Respondent performed acupuncture and SCS (?) technique to bilateral trapezius, bilateral splenius, capitis and cervical areas on Patient C.

90. On June 13, 2000, Respondent billed for treatment of severe vascular headaches with Manual Therapy, Myofascial Release and Acupuncture for a total of $100, using the ICD-9 code for Vascular Headaches.

91. On June 16, 2000, Respondent billed for Manual Therapy, Myofascial Release, and Acupuncture for a total of $100, using ICD-9 code for Vascular Headaches.

92. Respondent did not document any office visit on June 16, 2000, including performance of physical therapy or acupuncture care.

93. On June 21, 2000, Patient C presented with left shoulder ache, right quadriceps pain, right hip pain, and lower back pain.

94. Respondent performed acupuncture, manual therapy, and myofascial release.

95. On June 21, 2000, Respondent billed for treatment of low back pain with Manual Therapy, Myofascial release and Acupuncture for $100, using ICD-9 codes for Lumbar Dysfunction and Sacral Dysfunction.

96. On July 5, 2000, Patient C presented sleep problems, stomachaches; right sided headaches, familial problems, and lower back pain.

97. Respondent performed acupuncture, manual therapy, and myofascial release.

98. On July 5, 2000, Respondent billed for Manual Therapy, Myofascial Release, Acupuncture for $100 for treatment of "low back pain." Respondent did not use any ICD-9 code or make any diagnosis.

99. On July 12, 2000, Patient C presented with right-sided visual disturbances and occipital headaches bilaterally, and reported that after treatment she is "sad and angry."

100. Respondent performed acupuncture, suboccipital release and upper trapezius massage.

101. On July 12, 2000, Respondent billed for treatment of left quadriceps pain with Massage, Myofascial Release and Acupuncture for a total of $100, using ICD-9 codes for Tension Headaches and Lower Extremity Dysfunction.

102. On July 19, 2000, Patient C presented with complaints of being "very angry, crying a lot, very sad, low self-esteem, increased cervical pain and headache."

103. Respondent performed acupuncture, manual therapy, and myofascial release.

104. On July 19, 2000, Respondent billed for treatment of anterior thoracic pain with Manual Therapy, Myofascial Release, and Acupuncture for a total of $100, using ICD-9 code for Thoracic Dysfunction.

105. On July 26, 2000, Patient C presented with emotional symptoms of "overwhelming feelings of sadness."

106. Respondent performed acupuncture, manual therapy, and myofascial release.

107. On July 26, 2000, Respondent billed for treatment of left lower extremity pain with Manual Therapy, Myofascial Release, and Acupuncture for $100, using ICD-9 codes for Lumbar Dysfunction and Sacral Dysfunction.

108. On August 8, 2000, Patient C presented with complaint of lower back pain, secondary to moving a cabinet, restless legs when sleeping and left quadriceps pain.

109. Respondent performed acupuncture, manual therapy, and myofascial release.

110. On August 8, 2000, Respondent billed for treatment of low back pain with Manual Therapy, Myofascial Release, and Acupuncture for $100, using ICD-9 codes for Lumbar Dysfunction and Sacral Dysfunction.

111. On August 18, 2000, Patient C presented with left sided headache.

112. Respondent performed acupuncture, adjusted left mid ribs, thoracic mobilization and myofascial release.

113. On August 18, 2000, Respondent billed for treatment of left thoracic pain with Manual Therapy, Myofascial Release, and Acupuncture for $100, using ICD-9 codes for Thoracic Dysfunction and Rib Cage Dysfunction.

114. On August 22, 2000, Patient C presented with intractable headache, TOP (?), and SCM upper trapezius and splenius capitis.

115. Respondent performed acupuncture, myofascial release, and manual therapy.

116. On August 22, 2000, Respondent billed for treatment of low back pain with Manual Therapy, Myofascial Release, and Acupuncture for $100, using ICD-9 codes for Thoracic Dysfunction and Lumbar Dysfunction and Pelvic/Hip Dysfunction.

117. On September 19, September 25, October 5, October 13, October 26, November 24, December 4, and December 27, 2000, Patient C presented with a variety of symptoms, including, low back pain, at times in the right lumbar area with radiation, tension headaches, migraine headaches, abdominal cramps, left neck ache, left thorax ache, right hip pain, left upper trapezius and splenius muscle spasm, and emotional issues.

118. Respondent performed various treatments including acupuncture, manual therapy, and myofascial release.

119. In September, October, November and December 2000, Respondent billed Patient C for treatment of low back pain, intractable migraine headache, left cervical neck spasm and pain, with a variety of modalities including Manual Therapy, Myofascial Release, Acupuncture[10], and Therapeutic Exercise, Neuromuscular Re-education, for $100, using a variety of ICD-9 codes for Tension Headaches, Migraine Headaches, Head/TMJ Dysfunction, Cervical Dysfunction, Thoracic Dysfunction, Lumbar Dysfunction, Sacral Dysfunction and Pelvic/Hip Dysfunction.

120. Patient C presented on January 19, January 31, February 8, February 26, March 22, May 2, May 31, August 23, October 30, December 7, December 31, 2001 and January 8, 2002 with complaints of headaches, left upper trapezius pain, aches and pains in back and shoulders, bilateral scapular and midback pain, left buttock, hip, calf, right knee, mid thigh and ankle pain, right sided fascial paresthesia, and emotional issues of anxiety and depression.

121. Respondent continued to treat Patient C on each of these dates with acupuncture, manual therapy, and myofascial release.

122. Respondent billed Patient C $100 for all of the above enumerated visits, using CPT codes for therapeutic exercise, neuro-muscular re-education, manual therapy and myofascial release. Respondent never billed for the acupuncture treatment.

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[10] Respondent stopped billing Patient C for acupuncture treatment as of October 13, 2000, although he continued to provide acupuncture treatment on every visit through January 8, 2002.

123. Respondent completed insurance re-imbursement forms for all of Patient C's visits.

124. Respondent failed to meet accepted standards in delivering physical therapy care, failed to meet requirements for documentation, and submitted a false statement to collect a fee in regard to Patient C in that he:

a. Did not obtain an adequate history;

b. Did not perform a physical therapy evaluation, with measurable and objective data;

c. Did not adequately document the conditions and diagnoses for which he provided physical therapy;

d. Did not have a consistent plan of care through all of the subsequent visits;

e. Failed to perform a physical therapy re-evaluation at any time during the year and a half that he treated Patient C;

f. Failed to refer Patient C for mental health counseling; and

g. Beginning on October 13, 2001, failed to bill Patient C, and failed to state on insurance re-imbursement forms, that he provided acupuncture treatment.

Patient D

125. Patient D (d.o.b. 2/13/64), then a 37 year old female, initially presented to Respondent on August 22, 2001, on referral from her dentist's office, with a complaint of neck, shoulder and lower back pain.

126. Respondent documented on the Preface Sheet that Patient D has headaches with limited cervical range of motion, tension, migraines, and intermittent low back pain. Respondent documented "good sexual health." Respondent documented a major physical abnormality as "scoliosis."

127. Respondent did not assess the level of the scoliosis, the shape, how extensive and whether there is involvement of any other part of the body.

128. Respondent documented a "structural exam" as neck rotation "↓'d L SB (decreased left side bending); roL (sic?)."

129. Respondent did not document back alignment or range of motion of the lumbar region. Respondent did not document other flexion or rotation.

130. Respondent did not document performance of a physical therapy evaluation of Patient D. Respondent did not obtain any measurements or repeatable objective tests.

131. Respondent documented a "traditional diagnosis" of neck spasms.[11]

132. Respondent performed acupuncture, manual therapy, myofascial release to clavicals, scalenes, and upper trapezius muscles.

133. Respondent billed Patient D for manual therapy, and myofascial release for a total of $100, using the ICD-9 code for Cervical Dysfunction.

134. Respondent failed to meet accepted standards in delivering physical therapy care, failed to meet requirements for documentation, and submitted a false statement to collect a fee in regard to Patient D in that he:

a. Recorded only subjective data;

b. Failed to perform a physical therapy evaluation with measurable and objective data;

c. Provided physical therapy treatment without an evaluation; and

d. Failed to bill for acupuncture treatment that he provided.

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[11] Neck spasms are not a traditional diagnosis in traditional Chinese medicine.

Patient E

135. Patient E (d.o.b.10/28/72), then a 28 year old female, initially presented to Respondent on May 2, 2001, on referral from a friend, with complaint of sciatic pain in her right leg, noting history of headaches and lower back surgery in October 2000, and seeking "realignment and exercises to strengthen her back." She also stated on the Outpatient Form that she had seen a neurologist and had an MRI and steroid injection.

136. Respondent documented on a Preface Sheet, among other things, low back pain with right lower extremity radiation, migraines every 3 months, left scapular pain and L4-5 herniated disc surgery. Respondent noted "no sexual issues, no physical abuse problem."

137. Respondent did not document the results of the MRI, whether there were any fractures, the effects of the steroid injection, and the results from the neurologist's evaluation.

138. Respondent documented a structural exam as "tight B (bilateral) L hip ↑, right hip ↓. Respondent did not document whether this was a structural or functional problem and does not specify which bony landmark he used. The only objective data Respondent documented was "leg length ↑'d L LE (left lower extremity)."

139. Respondent did not document performance of a physical therapy evaluation of Patient E. Respondent did not obtain any measurements or repeatable objective tests, including a straight leg raise test and checking Patient E's leg muscles.

140. Respondent documented a "traditional diagnosis" of low back pain.[12]

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[12] Low back pain is not a traditional diagnosis in Chinese medicine.

141. Respondent performed acupuncture, manual therapy, myofascial release to bilateral iliacus, lumbar/thoracic erector, correct left lower extremity discrepancy.

142. Respondent billed for treatment of low back pain with manual therapy, myofascial release, and acupuncture therapy for a total of $100, using ICD-9 codes for Lumbar Dysfunction, Sacral Dysfunction, and Pelvic/Hip Dysfunction.

143. Patient E returned to Respondent on May 10, 2001, with complaint of "felt good for about 3 days, right low back pain."

144. Respondent performed acupuncture and manual therapy to left psoas and piriformis muscles.

145. Respondent billed Patient E for treatment of low back pain with manual therapy, myofascial release, and acupuncture therapy for a total of $100, using ICD-9 codes for Lumbar Dysfunction, Sacral Dysfunction, and Pelvic/Hip Dysfunction.

146. Patient E returned to Respondent on May 22, 2001, with complaint of right low back pain, hip with butt pain.

147. The only physical therapy data Respondent documented for this visit was "R upslip with LLD of shortened R LE. Tender lumbar erector, distal psoas."

148. Respondent performed acupuncture and manual therapy on right iliacus, and left lower correction.

149. Respondent billed Patient E for treatment of low back pain with manual therapy, myofascial release, and acupuncture therapy for a total of $100, using ICD-9 codes for Lumbar Dysfunction, Sacral Dysfunction, and Pelvic/Hip Dysfunction.

150. Patient E returned for treatment on July 11, 2001, with comment of "substantial decrease in lower back pain."

151. Respondent did not perform a re-evaluation after the nearly two- month gap in treatment.

152. Respondent performed acupuncture and "massage upper ½."

153. Respondent did not document where he performed massage and why.

154. Respondent billed Patient E for treatment of low back pain with manual therapy, myofascial release, and acupuncture therapy for a total of $100, using ICD-9 code for Pelvic/Hip Dysfunction.

155. Patient E returned for treatment on July 18, 2001, with a complaint of "increased activity causing increased low back (pain), had migraine headache yesterday."

156. Respondent performed acupuncture and "upper ½ massage."

157. Respondent did not document where he performed massage and why.

158. Respondent did not obtain any objective data for physical therapy intervention.

159. Respondent billed Respondent billed Patient E for treatment of low back pain with manual therapy, myofascial release, and acupuncture therapy for a total of $100, using ICD-9 codes for Lumbar Dysfunction, Sacral Dysfunction and Pelvic/Hip Dysfunction.

160. Patient E returned for treatment on September 21, 2001, with complaint of right low back and gluteus medius pain.

161. Respondent did not perform a re-evaluation although it had been two months since Patient E's last treatment. There is no objective data, no measurements of motion and no evaluation.

162. Respondent performed acupuncture and myofascial release, manual therapy to lumbar erector, psoas, iliacus, and right piriformis.

163. Respondent billed Patient E for treatment of low back pain with Manual Therapy, Myofascial Release, and Acupuncture Therapy, for a total of $100, using ICD-9 codes for Lumbar Dysfunction and Sacral Dysfunction.

164. Patient E returned for treatment on October 11, 2001, with complaint of left cervical neck pain. Respondent noted that Patient E was "feeling unable to let people close to her and issues surrounding sexuality.'

165. Respondent performed acupuncture and manual therapy to left upper traps, splenius capitis, and scalenes.

166. Respondent billed Patient E for treatment of cervical neck pain with NM Re-education, Massage Therapy, and Acupuncture Therapy for a total of $100, using ICD-9 code for Cervical Dysfunction.

167. Respondent failed to meet accepted standards in delivering physical therapy care, failed to meet the requirements for documentation, and submitted a false statement to collect a fee in regard to Patient E in that he:

a. Recorded only subjective data;

b. Failed to perform a physical therapy evaluation with measurable and objective data;

c. Failed to provide an objective basis to determine a plan of care and treatment goals;

d. Failed to provide consistency in his plan of care and treatment goals;

e. Failed to perform and document re-evaluation for interruptions in treatment; and

f. Billed for myofascial release without documentation of having performed the treatment.

PATIENT F

168. Patient F (d.o.b. 4/28/67), then a 34 year old female, initially presented to Respondent on March 7, 2001. Patient F completed an Outpatient Form and indicated that her complaint of sight and hearing problems and stress in the back and neck occurred after dancing the night before. She indicated that she had had a CT scan within the past year.

169. Respondent documented on a Preface Sheet and noted a history of being struck as a pedestrian 10 years ago and having fractured her right humerus, occipital area, pelvic bone bilaterally, and lumbar (?). Respondent noted that her sexual health is "fair, with decreased orgasms."

170. Respondent did not document any "Structural Exam."

171. Respondent did not document performance of a physical therapy evaluation of Patient F. Respondent did not obtain any measurements or repeatable objective tests.

172. Patient F presented on March 13, March 20, March 27, April 3, April 10, April 17, April 24, May 1, May 15, May 29, 2001 with continued cervical neck pain, "feeling exhausted, disconnected", knee discomfort, sinus problems, and anxiety.

173. Respondent performed treatments on all of the above dates, including acupuncture, myofascial release, and manual therapy.

174. Respondent billed Patient F for treatment of right lumbar, cervical pain, bilateral knee pain and anxiety with Manual Therapy, Myofascial Release, and

Acupuncture Therapy for a total of $100, using ICD-9 codes for Cervical Dysfunction and Lumbar Dysfunction, Sacral Dysfunction, Upper Extremity Dysfunction, Lower Extremity Dysfunction, Pelvic/hip Dysfunction.

175. Respondent failed to meet accepted standards for delivering physical therapy care and requirements for documentation in regard to Patient F in that he:

a. Recorded only subjective data;

b. Failed to perform a physical therapy evaluation with measurable and objective data; and

c. Failed to provide an objective basis to determine a plan of care and treatment goals.

PATIENT G

176. Patient G (d.o.b. 3/14/66), then a 34 year old female, initially presented to Respondent on September 26, 2001, on referral from a physician. Patient G complained that her "left forearm hurts from the elbow into her fingers" and noted that it had been x-rayed on September 23, 2001.

177. Respondent documented on the Preface Sheet "left UE tennis elbow, migraines secondary to MSG, left temporal headache and noted restless legs syndrome. Respondent noted that Patient G had decreased libido and is "multiorgamsic."

178. Respondent did not document a "Structural Exam."

179. Respondent did not document performance of a physical therapy evaluation of Patient G. Respondent did not obtain any measurements or repeatable objective tests.

180. Respondent documented a traditional diagnosis of "elbow-forearm pain."[13]

181. Respondent performed acupuncture, manual therapy, and myofascial release.

182. Respondent billed Patient G for treatment of left tennis elbow as a new office visit, manual therapy, and myofascial release for a total of $100, using ICD-9 codes for Cervical Dysfunction and UE Dysfunction.

183. On October 4, 2001, Patient G presented with complaint of "feeling stressed, headache yesterday, no complaint of arm pain, fingers feel like a balloon and left shoulder with discomfort."

184. Respondent did not document performance of a physical therapy evaluation of Patient G. Respondent did not obtain any measurements or repeatable objective tests.

185. Respondent performed acupuncture, neuro-muscular re-education, and manual therapy to left scalenes, upper trapezius, splenius, and levelor scapulae muscles.

186. Respondent billed Patient G for treatment of left tennis elbow with therapeutic exercise, NM Re-Education and manual therapy for a total of $100, using ICD-9 codes for Cervical Dysfunction and UE Dysfunction.

187. On October 11, 2001, Patient G presented with complaint of feeling depressed but no complaint of left upper extremity pain.

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[13] Elbow-forearm pain is not a traditional diagnosis in Chinese medicine.

188. Respondent did not document performance of a physical therapy evaluation of Patient G. Respondent did not obtain any measurements or repeatable objective tests.

189. Respondent performed acupuncture, manual therapy and myofascial.

190. Respondent billed Patient G for treatment of left upper extremity paresthesia with therapeutic exercise NM Re-Education, and manual therapy for a total of $100, using ICD-9 codes for Cervical Dysfunction and UE Dysfunction.

191. On October 18, 2001, Patient G presented with complaints of feeling either "real high or real low," TOP (?) to left deltoid, scalenes, and upper trapezius.

192. Respondent did not document performance of a physical therapy evaluation of Patient G. Respondent did not obtain any measurements or repeatable objective tests.

193. Respondent performed acupuncture, manual therapy, and myofascial release to left splenius, scalenes, and upper trapezius.

194. Respondent billed Patient G for treatment of cervical neck pain with therapeutic exercise, manual therapy, and myofascial release for a total of $100, using ICD-9 codes for Cervical Dysfunction.

195. Respondent failed to meet accepted standards in delivering physical therapy care, failed to meet requirements for documentation, and submitted a false statement to collect a fee in regard to Patient G in that he:

a. Recorded only subjective data;

b. Failed to perform a physical therapy evaluation with measurable and objective data;

d. Failed to provide an objective basis to determine a plan of care and treatment goals; and

e. Failed to bill for acupuncture treatment that he performed.

Patient H

196. On or about April 30, 2001, Patient H, then a 27 year old female (DOB 9/18/74) presented to Respondent with complaints associated with a recent left wrist fracture.

197. Patient H completed an Outpatient Form. One of the questions on the form is, " Who referred you to the physical therapist?"

198. In response to the question on the form, "What are your goals for physical therapy?" Patient H wrote, "100% of wrist strength/mobility back."

199. On a Preface Sheet, Respondent documented the presenting symptom as "left scaphoid fractured with pinning." Respondent documented "healthy sex life."

200. Respondent did not document performance of a physical therapy evaluation of Patient H. Respondent did not obtain any measurements or repeatable objective tests.

201. Respondent performed acupuncture on Patient H's wrist.

202. Respondent did not document performance of any physical therapy modalities.

203. Respondent billed Patient H for treatment of "status post wrist fracture" with therapeutic exercise, manual therapy, and myofascial release for a total of $75, using ICD-9 code for Upper Extremity Dysfunction.

204. Respondent failed to meet accepted standards in delivering physical therapy care, failed to meet requirements for documentation, and submitted a false statement to collect a fee in regard to Patient H in that he:

a. Recorded only subjective data;

b. Failed to perform a physical therapy evaluation with measurable and objective data;

c. Failed to provide an objective basis to determine a plan of care and treatment goals; and

d. Failed to bill for acupuncture treatment that he performed; and

e. Failed to perform physical therapy treatment for which he billed.

Patients A, B, C, D, E, F, G and H

205. Respondent failed to meet accepted standards in delivering physical therapy care, failed to meet the requirements for documentation, and submitted false statements to collect a fee in regard to Patients A - H in that:

a. The Preface Sheet, which is filled out by Respondent, contains only subjective information, which is pertinent mainly to acupuncture. The Preface Sheet lists the treatment provided, which includes both acupuncture and physical therapy;

b. Respondent documents his evaluation on a form that is almost all acupuncture related with minimal space for any type of physical therapy evaluation information. In all the records, there is minimal information documented in this extremely small area relevant to physical therapy;

c. There is no physical therapy evaluation sheet and no physical therapy evaluation for all of the patient's charts reviewed;

d. Respondent provides minimal, if any, objective information. There are no measurements, ROM, MMT, or functional status. Occasionally Respondent gives tenderness on palpation information;

e. In all the cases, Respondent provided physical therapy treatment without sufficient evaluation to provide an adequate physical therapy diagnosis or a rationale for choice of treatment;

f. The treatment that Respondent provided does not give specifics to enable another physical therapist to reproduce the treatment;

g. Some patients had treatment weeks apart, but Respondent did not perform a re-evaluation for PT purposes;

h. Respondent bases his "evaluation" of patients on subjective data and holistic health without objective data to substantiate the PT intervention provided;

i. Charged every patient[14] $100 per visit, regardless of the treatment received; failed to reflect the nature of the office visit in the bill, billed for treatments he did not perform, and failed to bill for treatment that he did perform.

CONCLUSIONS OF LAW

Respondent failed to meet accepted standards in delivering physical therapy care, failed to respect the dignity of the patients, and engaged in sexual misconduct, in violation of H.O. § 13-316(a)(26) and COMAR 10.38.02.01B and 10.38.02.02B(2), (6), (8), and (11); failed to meet the requirements for documentation, in violation of H.O. § 13-316(a)(16) and COMAR 10.38.03.02-1; and submitted false statements to collect a fee, in violation of H.O. § 13-316(a)(15).

[14] Patient H was charged $75.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 2nd day of April, 2004, by a majority of the full authorized membership of the Board considering this case:

ORDERED that Respondent's license to practice physical therapy shall be subject to six (6) months **SUSPENSION**, with all six (6) months **STAYED**; and be it further

ORDERED that Respondent shall be subject to two (2) years **PROBATION** under the following terms and conditions:

1. Respondent shall enroll in a Board approved Individual ethics tutorial, as soon as possible, but no later than ninety (90) days after the date of this Consent Order; and shall successfully complete the tutorial;

2. Respondent authorizes the Board to submit to the tutor copies of the complete investigative file pertaining to this case, the Board's Amended Charges, and the Consent Order;

3. Respondent shall ensure that the ethics tutor provides the Board with a final report at the conclusion of the tutorial regarding Respondent's participation, cooperation and achievement;

4. Within thirty (30) days from the date of this Consent Order, Respondent shall submit to an initial review of six (6) patient charts randomly chosen by the Board from Respondent's private practice; and thereafter Respondent shall submit to four (4) additional chart reviews during the probationary period, consisting of review of six (6) patient charts at each review;

5. Within sixty (60) days of the date of this Consent Order, Respondent shall submit to the Board, a brochure describing Respondent's practice, for review and approval by the Board. Subject to approval by the Board, Respondent shall send a copy

of the brochure to all patients prior to the first office visit in his private practice; and during the probationary period, Respondent shall submit all revisions to the brochure to the Board for review and approval;

6. Respondent shall submit to the Board for approval, any other form of advertisement regarding his private practice of physical therapy;

7. Within one (1) year of the date of this Consent Order, Respondent shall successfully complete a Board-approved course in documentation;

8. Respondent shall be responsible for all costs associated with fulfilling the conditions of this Order; and be it further

ORDERED that if Respondent violates any of the probationary conditions, the **STAY of SUSPENSION SHALL BE IMMEDIATELY LIFTED PRIOR TO A HEARING**; and be it further

ORDERED that Respondent will comply and practice within all statutes and regulations governing the practice of physical therapy in the State of Maryland; and it is further

ORDERED that any violation of any of the terms of this Order shall constitute unprofessional conduct; and it is further

ORDERED that if Respondent fails to comply with the terms of this Consent Order, the Board, after notice and a hearing, and a determination of violation, may impose any other disciplinary sanctions it deems appropriate, including suspension and revocation, said violation being proved by a preponderance of evidence; and be it further;

ORDERED that Respondent shall not petition the Board for early termination of his probationary period or the terms of this Consent Order; and be it further

ORDERED that if Respondent has satisfactorily complied with all terms and conditions, and there are no outstanding complaints regarding Respondent's practice, Respondent may petition the Board for termination of probation without further terms or conditions after the **two (2) year** period imposed under this Consent Order; and be it further

ORDERED that if the Board has probable cause to believe that Respondent presents a danger to the public health, safety or welfare, the Board, without prior notice and an opportunity for a hearing, may summarily suspend the Respondent's license, provided that Respondent is given notice of the Board's action and an opportunity for a hearing within thirty (30) days after requesting same in accordance with Md. State Gov't Code Ann. § 10-226(c) (2000 Supp.); and be it further

ORDERED that this Consent Order is a public document pursuant to Md. State Gov't Code Ann. § 10-611 et seq., (1999 Repl. Vol.).

4-2-04
Date

Margery Rodgers, P.T.
Margery Rodgers, P.T.
Chairperson
Board of Physical Therapy Examiners

CONSENT

I, Raymond Schmidt, Jr., L.Ac., P.T., acknowledge that I am represented by legal counsel, Lois A. Fenner McBride, Esquire, and I have had the opportunity to consult with counsel before entering into and signing this document. By this consent, I hereby admit the Findings of Fact and Conclusions of Law, and submit to the foregoing Consent Order consisting of forty (40) pages.

I acknowledge the validity of this Consent Order as if entered 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 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 also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

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

4-1-04
Date

Raymond Schmidt Jr
Raymond Schmidt, Jr., L.Ac., P.T.
Respondent

Reviewed by:

L A Fenner McBride, Esq
Lois A. Fenner McBride, Esquire
Counsel for Respondent

STATE OF MARYLAND

~~CITY~~/COUNTY of Baltimore

I **HEREBY CERTIFY** that on this 1st day of April, 2004, before me, a Notary Public of the State and County aforesaid, personally appeared Raymond Schmidt, Jr., L.Ac., P.T., and made oath in due form of law that the foregoing was his/her voluntary act and deed.

AS WITNESS my hand and Notarial Seal.

Donna M. Inches
Notary Public

My Commission Expires: 2.24.2007