IN THE MATTER OF	*	**BEFORE THE STATE BOARD**
DIANA ENGLER, P.T.	*	**OF PHYSICIAL THERAPY**
License No.: 17448	*	**EXAMINERS**
Respondent	*	**Case No.: 01-BP-131**

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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 Diana Engler, P.T., (the "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:

(5) In the case of an individual who is authorized to practice physical therapy is grossly negligent;

(ii) In the direction of an individual who is authorized to practice limited physical therapy;

(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 further charged the Respondent with the following violations of the Code of Maryland Regulations (Code Md. Regs.) tit. 10, § 38.03.02 Standards:

K. The physical therapist shall provide direction, periodic on-site supervision, and instruction for the physical therapy assistant that is adequate to ensure the safety and welfare of the patient;

L. At least once in every ten visits or every 60 calendar days, whichever comes first, there shall be a joint on-site visit with treatment rendered by the physical therapist assistant under the direct supervision of the physical therapist. At this visit, the physical therapist is to assess the treatment performed by the physical therapist assistant, reevaluate the patient's program, and document the program.

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 1, 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 June 1, 1993.

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 physical therapy 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 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).

[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."

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. 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

18. Patient A, a male born in 1946, presented to Concentra on December 15, 1998 complaining of pain to his neck and left shoulder. Patient A reported that he had slipped and fallen in a work-related injury on the previous day.

19. Patient A was evaluated by a PT other than the Respondent as having cervical/thoracic muscle strains.

20. The Respondent treated Patient A on December 22, 1998. She noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) (2 units); Procedures - Therapeutic Exercise (97110) (2 units); and Tests - Manual Muscle Testing (95831) and Range of Motion (95851).[2]

21. The Respondent's documentation of the December 22, 1998 visit fails to support charging under the Test codes.

22. The Respondent treated Patient A on December 29, 1998. She noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) (2 units); Procedures - Therapeutic Exercise (97110) (2 units); Neuromuscular Re-

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

education (97112); Therapeutic Activity (97530); and Tests - Manual Muscle Testing (95831).

23. The Respondent's documentation of the December 29, 1998 visit fails to support charging under the Therapeutic Activity or Manual Muscle Test code. Moreover, the Respondent's documentation fails to support the charges under all three (3) of the Procedure codes.

Patient C[3]

24. Patient C, a male born in 1955, initially presented to Concentra on December 17, 1998 with complaints of lower back pain. Patient C reported that his injury occurred when he was attempting to restrain a patient that day.

25. Patient C was evaluated by a PT other than the Respondent on December 17, 1998. The treatment plan included modalities, myofascial release, lower trunk stretches and lumbar stabilization.

26. The Respondent treated Patient C on December 28, 1998. She noted the following charges for that visit: Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530); Tests - Range of Motion (95851). The Respondent's documentation fails to support charging for multiple units of Therapeutic Exercise, nor does it support charging under the Test code.

27. The Respondent treated Patient C on January 6, 1999. She noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) (2 units); Tests - Manual Muscle Testing (95831) and Range of Motion (95851).

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[3] The reviewer found that the Respondent's treatment and billing of Patient B was minimally acceptable. The Respondent is not charged with a violation of the Act with regard to Patient B.

28. The Respondent's documentation of the January 6, 1999 visit fails to support charging for two (2) units of Therapeutic Exercise or under either of the Test codes.

Patient D

29. Patient D, a female born in 1964, initially presented to Concentra on April 15, 1998. Patient D reported that she fell in a work-related injury on that date.

30. The Respondent evaluated Patient D on April 15, 1998. The Respondent's treatment plan states" "Continue ex[cerise] daily. ↑ exs and activity as tolerated. Re-eval in 3-4 days." Modalities are not included in the treatment plan.

31. Patient D returned for treatment on April 17 and April 20, 1998, and was treated by a PTA under the Respondent's supervision. On both occasions, the PTA charged for modalities [(Hot/Cold Packs (97010) and Electrical Stimulation (97041)] even though they had not been included in the treatment plan.

32. The Respondent knew, or should have known the permissible activities that fall within the scope of a PTA license. The Respondent, by permitting the PTA to add modalities to the treatment plan and to make assessments regarding the patient's status, violated the Act by knowingly allowing the PTA to practice beyond the scope of the PTA's license.

33. The Respondent next treated Patient D on April 22, 1998. In addition to charging for modalities, the Respondent noted the following charges

for that visit: Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112) and Therapeutic Activity (97530).

34. The Respondent's documentation of the visit fails to support charging under the Therapeutic Activity code, nor does it support charging under all three (3) of the procedures codes.

35. The Respondent treated Patient D on April 24, 1998. She noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112), and Therapeutic Activity (97530) (2 units).

36. The Respondent's documentation of the April 24, 1998 visit fails to indicate the Therapeutic Activities were conducted. The Respondent's documentation therefore fails to support charging for two (2) units of Therapeutic Activity.

37. The Respondent treated Patient D on April 28, 1998. She noted the following charges for that visit: Evaluation - PT Re-evaluation Established Patient (97799-0006); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530).

38. The Respondent's documentation of the April 28, 1998 visit fails to support charging under the Therapeutic Activity code.

39. Patient D returned for treatment on May 1, 4 and 6, 1998. On each of those visits, Patient D was treated by a PTA under the Respondent's supervision. On the notes for those visits, the PTA documented objective findings, assessments, and Patient D's discharge. The PTA also charged for

conducting Range of Motion tests. The Respondent did not sign or co-sign the notes for these visits.

40. The Respondent knew, or should have known the permissible activities that fall within the scope of a PTA license. The Respondent, by permitting the PTA to charge under the test code and to make assessments regarding the patient's status and to discharge the patient from treatment, violated the Act by knowingly allowing the PTA to practice beyond the scope of the PTA's license.

41. On July 8, 1998, Patient D returned for treatment on July 8, 1998 complaining that she had injured her knee when she slipped on a wet floor earlier that day. The Respondent evaluated Patient D and noted that she was to continue increasing her activities and exercises.

42. The Respondent treated Patient D on July 9, 1998. She noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530).

43. The Respondent failed to document that Patient D performed Therapeutic Activities on July 9, 1998.

44. The Respondent treated Patient D at her next visit on July 10, 1998. She noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530).

45. The Respondent failed to document that Patient D performed Therapeutic Activities on July 10, 1998.

Patient E

46. Patient E, a female born in 1970, initially presented to Concentra on November 10, 1998 with a knee sprain she had sustained in a work-related injury.

47. The Respondent treated Patient E on November 17, 1998, her third visit to Concentra. She 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); and Tests - Range of Motion (95851).

48. The Respondent's documentation of the November 17, 1998 visit fails to support charging under the Therapeutic Activity code.

49. Patient E returned for treatment on November 20, 1998 and was treated by a PTA. The PTA noted the following charges for the visit: Procedures - Therapeutic Exercise (97110) (2 units) and Tests - Range of Motion (95851). The PTA also documented the patient's discharge. The Respondent did not co-sign the discharge.

50. The Respondent knew, or should have known the permissible activities that fall within the scope of a PTA license. The Respondent, by permitting the PTA to charge under the test code, make assessments regarding the patient's status and discharge the patient from treatment, violated the Act by knowingly allowing the PTA to practice beyond the scope of the PTA's license.

Patient F

51. Patient F, a male born in 1976, initially presented on December 22, 1998, after sustaining a work-related laceration to his left thumb.

52. The Respondent evaluated Patient F on December 22, 1998. Her treatment plan includes heat, active exercise and gentle stretching.

53. The Respondent next treated Patient F on December 28, 1998 and recommended that the patient be discharged from treatment. She noted the following charges for that visit: Tests: Manual Muscle - Hand (95832), Range of Motion (95851) and Jamar 1 (97750).

54. The Respondent's documentation of the December 28, 1998 visit fails to support charging under the Test codes.

Patient G

55. Patient G, a male born in 1942, initially presented on November 11, 1997 with lumbar strain. The Respondent evaluated the patient and included in the treatment plan: exercise, joint mobilization and modalities.

56. The Respondent treated Patient G on November 14, 1997. She noted the following charges for that visit: Modalities - Hot/Cold Packs (97010), Electrical stimulation (97041) and Ultrasound (97035); and Procedures - Therapeutic Exercise (97110), Myofascial Release (97250) and Therapeutic Activity (97530).

57. The Respondent's documentation of the November 14, 1997 visits fails to support charging under the Therapeutic Activity code as no exercise activities are listed on the flow chart for that date.

58. The Respondent next treated Patient G on November 20, 1997. She noted the following charges for that visit: Modalities - Electrical Stimulation (97041) and Phono w/ Fluoc (97139); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112), Myofascial Release (97250) and Therapeutic Activity (97530); Tests- Range of Motion (95851).

59. The Respondent's documentation of the November 20, 1999 visits fails to support charging under the Therapeutic Activity as none is noted. Moreover, the Respondent's documentation fails to support charging under all three of the remaining Procedures codes and the Tests code.

60. On December 18, 1997, the Respondent treated Patient G and noted the following charges: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110), Massage (97124) and Therapeutic Activity (97530).

61. The Respondent 's documentation of the December 18, 1997 visit fails to support charging under the Therapeutic Activity (97530) code as no Therapeutic activities were documented.

62. The Respondent treated Patient G on December 19, 1997 and noted the following charges: Evaluation - PT Re-evaluation - Established Patient (97799-0006); Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530).

63. The Respondent's documentation of the December 19, 1997 visits fails to support charging under the Therapeutic Activity code as no Therapeutic Activities were documented.

64. A PTA under the Respondent's supervision treated Patient G on several visits including: November 12, 1997, November 17, 1997, November 19, 1997, November 21, 1997, November 24, 1997, November 25, 1997, November 26, 1997, December 2, 1997, December 8, 1997, December 11, 1997, December 15, 1997, December 16, 1997, December 17, 1997 and December 23, 1997. The PTA documented objective findings and assessments during these visits. In addition, the PTA performed and charged for Range of Motion tests on several of the visits (November 2, 17, 26 and December 2, 11, and 16, 1997). The Respondent knew, or should have known the permissible activities that fall within the scope of a PTA license. The Respondent, by permitting the PTA to charge under the test code, document objective findings and make assessments, violated the Act by knowingly allowing the PTA to practice beyond the scope of the PTA's license.

65. Patient G returned to treatment on August 14, 1998. The Respondent noted the following charges for that visit: Evaluation - PT Re-evaluation - Established Patient (97799-0006); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530); and Tests - Range of Motion (95851).

66. The Respondent's documentation fails to support charging under the evaluation code because she failed to document the evaluation, even though

it had been several months since the patient's last treatment. In addition, her documentation fails to support charging for two (2) units of Therapeutic Exercise.

67. A PTA treated Patient G for five visits from August 18, 1998 through August 28, 1998. The PTA conducted Range of motion measurements on two (2) visits and documented objective findings. The PTA also documented Patient G's discharge from treatment. The Respondent failed to co-sign or sign the PTA's progress notes.

68. The Respondent knew, or should have known the permissible activities that fall within the scope of a PTA license. The Respondent, by permitting the PTA to charge under the test code, document objective findings, make assessments and document the patient's discharge, violated the Act by knowingly allowing the PTA to practice beyond the scope of the PTA's license.

69. The Respondent was interviewed by the Board during its investigation of this case. The Respondent's statements, *inter alia,* did not justify the use of therapeutic activities and therapeutic exercise codes in many instances, nor did they justify the use of the test and measures codes. With regard to Patient A, she was unable to justify the use of duplicate procedure codes and admitted to excessive charging for therapeutic activities. With regard to Patient G, her statements failed to justify the PTA's repeated use of test and measurement codes, nor did it justify the PTA's documentation of the patient's discharge without the Respondent co-signing the discharge.

70. The Respondent's statements with regard to the charges for which she is alleged herein to have failed to have provided adequate documentation likewise fails to support the use of those codes.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board finds that the Respondent violated Md. Health Occ. Code Ann. §§ 13-316(5)(ii), (15), (16), (21), and (26). The Board also finds that the Respondent violated Code Md. Regs. tit. 10, § 38.03.02(K) and (L), and § 38.03.02-1.

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 20th 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 two (2) years, subject to the following conditions:

1. The Respondent shall pay a fine in the amount of three thousand dollars ($ 3,000.00), to be paid prior to the termination of probation;

2. Within the first year of probation, 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, Diana Engler, 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.

5-16-2003
Date

Diana Engler PT
Diana Engler, P.T.
Respondent

STATE OF: MD

CITY/COUNTY OF: Howard

I HEREBY CERTIFY that on this 16 day of May, 2003, before me, a Notary of the State of MD and the City/County of Howard, personally appeared Diana Engler, 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.

Notary

My Commission expires: 9/1/06