IN THE MATTER OF	*	**BEFORE THE STATE BOARD**
CAMERON K.S. JONES, P.T.	*	**OF PHYSICAL THERAPY**
License No.: 22379	*	**EXAMINERS**
Respondent	*	**Case Number: PT 16-31**

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CONSENT ORDER

On May 22, 2018, the Maryland State Board of Physical Therapy Examiners (the "Board") charged **CAMERON K. S. JONES, P.T.** (the "Respondent"), License Number 22379, with violations of certain provisions of the Maryland Physical Therapy Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 13-101 *et seq.* (2014 Repl. Vol. & 2016 Supp.). Specifically, the Board charged the Respondent with violations of the following provisions of H.O. § 13-316:

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, or restricted license to any applicant, reprimand any licensee or holder of a restricted license, place any licensee or holder of a restricted license on probation, or suspend or revoke a license or restricted license if the applicant, licensee or holder:
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> ...
>
> (14) Submits a false statement to collect a fee;
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> (15) Violates any provision of this title or rule or regulation adopted by the Board;
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> ...
>
> (19) Commits an act of unprofessional conduct in the practice of physical therapy or limited physical therapy;
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> (20) Grossly overutilizes health care services;
>
> ...
>
> (25) Fails to meet accepted standards in delivering physical therapy...[.]

(b) Cancellations, no-shows;

(c) Modalities, or procedures, or both, with any changes in the parameters involved and areas of body treated;

(d) Objective status;

(e) Response to current treatment, if any;

(f) Changes in plan of care[.]; and

(g) Signature, title (PT) and license number.

(3) Reevaluation, by including the following information in the report, which may be in combination with the visit note, if treated during the same visit:

(a) Date;

(b) Number of treatments since the initial evaluation or last reevaluation;

(c) Reevaluation, tests, and measurements of areas of body treated;

(d) Changes from previous objective findings;

(e) Interpretation of results;

(f) Goals met or not met and reasons;

(g) Updated goals;

(h) Updated plan of care including recommendations for follow-up;

(i) Signature, title (PT), and license number;

(4) Discharge, by including the following information in the discharge summary, which may be combined with the final visit note, if seen by the physical therapist on the final visit and written by the physical therapist:

(a) Date;

The Board further charges the Respondent with violations of Md. Code Regs. 10.38.03.02 – Standards of Practice as follows:

A. Physical Therapists.

...

(2) The physical therapist shall:

(a) Exercise sound professional judgment in the use of evaluation and treatment procedures;

(b) Provide:

(i) Physical therapy services to not more than an average of three patients per clinical treatment hour per calendar day, excluding group therapy; and

(ii) Each patient with adequate treatment time consistent with accepted standards in delivering physical therapy care;

...

(g) Reevaluate the patient as the patient's condition requires, but at least every 30 days, unless the physical therapist, consistent with accepted standards of physical therapy care, documents in the treatment record an appropriate rationale for not reevaluating the patient[.]

The Board further charges the Respondent with violations of Md. Code Regs. 10.38.03.02 – 1 – Requirements of Documentation as follows:

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

...

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

(a) Date;

(b) Reason for discharge;

(c) Objective status;

(d) Recommendations for follow-up; and

(e) Signature, title (PT), and license number.

On September 19, 2018, a Case Resolution Conference ("CRC") with regard to this matter was held by a panel of the Board. As a result of the DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. At all times relevant to the charges herein, the Respondent was licensed to practice physical therapy ("PT") in the State of Maryland. The Respondent was originally licensed on October 10, 2007. The Respondent's license is scheduled to expire on May 31, 2019.

2. At all times relevant to the charges, the Respondent was employed by a physical therapy practice ("Practice 1") that is owned by a hospital in Southern Maryland ("Hospital 1").[1] The Respondent was the Director of the Metabolic Service at Practice 1.

3. In or around February 2013, the Respondent entered into an Employment Agreement with Practice 1 that, *inter alia,* provided that the Respondent receive

[1] Names of facilities, patients and other individuals are confidential.

33.33% of all profits accruing to Practice 1 from all PT metabolic services performed under the Respondent's responsibility.

4. The Respondent had attended a mandatory Medicare documentation course in September 2014, and documentation training sessions in January 2013 and July 2012.

5. On or about April 7, 2016, the Board received a complaint from Hospital 1 regarding the Respondent's inappropriate billing practices. Specifically, Hospital 1 reported to the Board as a result of the internal audit of its PT services, it was determined that the Respondent's improper and deficient billing practices had resulted in overbilling and the need to reimburse government and private insurance companies.

6. Hospital 1 further reported to the Board that the Respondent had been terminated from Practice 1 effective March 9, 2016.

7. Upon receipt of the complaint, the Board initiated an investigation that included review by a physical therapy expert (the "Expert") of ten of the Respondent's patient records and providing the Respondent the opportunity to respond to the complaint.

8. The pertinent findings of the Board's investigation are summarized below.

9. The Board's Expert reviewed Hospital 1's complaint, treatment/billing records for ten of the Respondent's patients and the Respondent's appointment schedule. The patients ranged in age from 48 to 89 years with various muscular/skeletal conditions. All the patients had private and/or government-provided insurance plans that required co-pays ranging from zero dollars to $35 a visit.

10. The Expert found the following deficiencies related to standards of practice when reviewing the Respondent's records:

I. Standards of Practice

a) Exercise of sound professional judgment – 10.38.03.02A(2)(a)

i. The Respondent failed to assess, recognize or follow-up on patients' subjective complaints;

ii. The Respondent failed to update treatments in response to change in patients' objective status, functional status or subjective report;

iii. The Respondent intermittently documented and billed for treatment modalities without parameters, evaluation or assessment. In many cases, the Respondent provided treatment in the absence of clinical support for those treatments;

iv. The Respondent consistently billed for three to four units of therapeutic procedure for a patient whom the Respondent had documented was short of breath and required frequent rest breaks;

v. The Respondent failed to demonstrate clinical decision-making; he documented and billed for treatment modalities and therapies without parameters, evaluation or assessment;

vi. The Expert concluded that it would not be safe for another therapist to assume care of any of the patients based on the Respondent's deficient documentation.

b) Exceeding maximum number of patients per clinical treatment hour – 10.38.03.02A(2)(b)

i. The Respondent consistently saw three to four patients a clinical hour and billed three to four units for each patient per treatment session;

ii. The Respondent failed to use group billing codes when appropriate. When the Respondent did use a group billing code he failed to document sufficiently to support that code;

iii. The Expert concluded that, based on the Respondent's documentation, it would not have been possible for him to have provided adequate treatment time to each patient.

c. Failure to re-evaluate patients at least every 30 days – 10.38.03.02A(2)(g)

i. The Respondent consistently failed to re-evaluate patients within the 30-day period. By example and not in limitation, the Respondent documented only three re-evaluations for a patient over a treatment period that exceeded 12 months;

ii. The Respondent failed to document his rationale for not performing patient re-evaluations.

d. Failure to meet accepted standards of practice – additional concerns

i. The Respondent consistently failed to provide home exercise programs to patients;

ii. The Respondent failed to provide patient education regarding posture, function, body mechanics, injury prevention, pain management, activity progression, or use of assistive devices or bracing;

iii. The Respondent consistently failed to document frequency or duration of treatment;

iv. The Respondent failed to adequately document treatment goals. On the occasions that the Respondent documented treatment goals, they were vague and it was difficult to determine whether a patient met the goals;

v. The Respondent consistently failed to change patient treatment plans despite lack of progress and occasional regression;

vi. The Respondent failed to document findings to support the need for the treatment modalities he used and for which he billed.

II. Requirements of Documentation

11. The Expert found the following deficiencies related to requirements of documentation when reviewing the Respondent's records:

i. When documenting initial evaluations, the Respondent consistently failed to document a patient's subjective assessment of their performance of functional activities, making it difficult to determine the patient's improvement during the course of treatment.

ii. The Respondent failed to document objective findings in almost all of his notes. In the Objective portion of treatment notes, the Respondent

consistently listed the type of treatment provided (therapeutic exercise, for example, with occasional references to the functional activities the treatment was intended to improve). The absence of adequate objective findings makes it very difficult to discern the actual deficits of a patient;

iii. The Respondent most frequently used an objective test, the Functional Movement Screen ("FMS"), to measure balance and function. The FMS was developed to measure compensatory movement patterns that may result from dysfunction and has greatest reliability in identifying athletes at risk for injury. The Respondent did not regularly use Tinetti, Berg Balance or Timed Up and Go ("TUG") tests which are more strongly validated and relevant for the patient population the Respondent was treating;

iv. The Respondent failed to document adequate patient assessments. In the Assessment portion of a note, the Respondent consistently documented statements such as, "no new report" and "doing more with treatment." When reviewing the Respondent's notes, the Expert was frequently unable to discern what part of the patient's body the Respondent was treating;

v. The Respondent included exercise flow sheets in the patient records. The Respondent noted the month and day of treatment but failed to document the year and failed to initial or sign the flow sheets;

vi. The Respondent included discharge summaries in only two of the ten records reviewed. Neither of those summaries contained objective information or objective findings.

III. Gross overutilization of heath care services

12. The Respondent treated patients for an excessive number of sessions without providing sound explanation or clarification explaining the medical necessity for the extended treatment duration.

13. As stated above, the Respondent consistently treated more than an average of three patients per clinical hour and billed three to four units for each patient per treatment session. The Expert opined that based on the Respondent's documentation, it would not have been possible for him to have provided adequate treatment time for each patient.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Board concludes as a matter of law that the Respondent violated Health Occ. § 13-316(14), (15), (19), (22), (25) and the Board's regulations under which he was charged.

ORDER

It is, on the affirmative vote of a majority of the quorum of Board, hereby

ORDERED that the Respondent shall be placed on probation for a minimum of **TWO YEARS**. During the probationary period, the Respondent shall comply with all of the following probationary terms and conditions:

1) The Respondent shall meet on a monthly basis with a Board-approved supervisor who shall review the Respondent's documentation and billing practices. After one year of supervision, the supervisor may petition the Board to terminate supervision;

2) The Respondent shall ensure that the supervisor provides quarterly reports to the Board. The supervisory reports shall summarize the Respondent's work quality, including documentation, billing, and compliance with the Maryland Physical Therapy Act;

3) An unsatisfactory report or reports may constitute violation of the Consent Order;

4) Within the first six months of probation, the Respondent shall successfully complete an in-person Board-approved remedial course in documentation and a separate in-person Board-approved remedial course in billing with an emphasis on Medicare billing, neither of which can count towards the Respondent's continuing education required for licensure renewal;

5) Within the first six months of probation, the Respondent shall pass the Board's closed-book law exam with a 90% passage rate;

6) Within 60 days, the Respondent shall pay a civil fine of $3,000.00. The Payment shall be by money order or bank certified check made payable to the Maryland Board of Physical Therapy, 4201 Patterson Avenue, Baltimore, Maryland 21215-0095; and it is further

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

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

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

11/5/18
Date

Kimberly Rotondo, P.T.A.
Chair
Maryland Board of Physical Therapy Examiners

CONSENT

I, Cameron K.S. Jones, PT, acknowledge that I have consulted with counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

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

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

10-25-18
Date

Cameron K.S. Jones, PT
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Charles

I HEREBY CERTIFY that on this 25 day of October 2018, before me, a Notary Public of the foregoing State and City/County personally appeared Cameron K.S. Jones, PT, and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Tracie Marie McDowell
Notary Public

My commission expires: 6/14/20