IN THE MATTER OF	*	BEFORE THE STATE BOARD
LINDA ECKERT OTS, P.T.	*	OF PHYSICAL THERAPY
Respondent	*	EXAMINERS
License No.: 16872	*	Case No.: 01-BP-130

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

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 Linda Eckert Ots, 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 over utilizes health care services;

(26) Fails to meet accepted standards in delivering physical therapy care.

The Board further charges 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 charges 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, 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. At all times relevant to the charges herein, the Respondent was licensed to practice physical therapy in the State of Maryland. The Respondent was originally licensed on December 10, 1990.

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 over utilized the following PT procedures, as identified by the Current Procedural Terminology ("CPT") assigned to them:

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

4. Thereafter, the Board conducted an investigation of services provided and claims submitted to IWIF by PTs and Physical Therapist 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

[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."

disease such as stroke, multiple sclerosis and ALD in order to document the patient's progression or regression. Both of these codes require the physical therapist to generate a separate report.

7. In the CPT manual, the term "separate procedure," as used in the description of the codes, 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).

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. Code 97110 is classified in the CPT manual 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. Code 97110 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. Teaching the patient how to perform the exercise is a component of therapeutic exercises 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. The Respondent billed under the neuromuscular re-education code in the absence of supporting documentation.

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

19. 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, initially presented to Concentra on July 6, 1998 with complaints of a sprained right ankle that he sustained in a work-related accident.

19. Patient A was evaluated on July 6, 1998 by a student PT. Although the Respondent's name appears on the health insurance claim form as the health care provider on that date, she failed to co-sign the student's evaluation.

20. The treatment plan for Patient A includes: therapeutic exercise, modalities, neuromuscular re-education and joint mobilization. The Respondent failed to document, or failed to cause to have documented, Patient A's ankle joint mobility.

21. Patient A returned for treatment on July 7, 1998 and was treated by the same student PT who had treated him on July 6. On the charge slip for the July 7, 1998 visit the student PT noted the following charges: Modalities - Cold Packs (97010); Procedures - Therapeutic Exercise (97110), Therapeutic Activity (97530); Tests - Manual Muscle Testing (95831) and Range of Motion (9851)[2]. The charge slip was co-signed by the Respondent.

22. The documentation prepared by the student PT, which was co-signed by the Respondent, fails to support charging under the Therapeutic Activity code or the test and measurement codes.

Patient B

23. Patient B, a female born in 1958, initially presented to Concentra on September 14, 1998 complaining of lumbar pain. Patient A reported that she had injured her back when she was attempting to restrain a patient.

24. Patient B was initially evaluated by a PT other than the Respondent on September 14, 1998. The treatment plan included "modalities/procedures to achieve goals."

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

25. Patient B was treated by a PTA during 7 offices visits from September 16, 1998 through October 2, 1998. On each of the visits, the PTA charged under codes that were not supported by the documentation of treatment. In addition, on September 21, 1998, September 25, 1998 and October 2, 1998, the PTA charged under the Range of Motion (95851) code and recommended that Patient B continue treatment.

26. The Respondent did not co-sign the PTA's recommendations, nor did she document that the PTA discussed her recommendations with her and that the Respondent concurred with the PTA's recommendations. 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, violated the Act by knowingly allowing the PTA to practice beyond the scope of the PTA's license.

27. The Respondent treated Patient B on October 6, 1998. She noted the following charges for this visit: Procedures - Neuromuscular Re-education (97112), Myofascial Release (97250); A[ctivities of] D[aily] L[iving] Training.

28. The Respondent documented that she charged for ADL training for "extended time spent discussing posture, shifting, changing position for symptom management." The Respondent's charge under the ADL code is not warranted in this case.

29. The Respondent treated Patient B on October 7, 1998. The Respondent noted the following charges for that visit: Modalities Cold Pack (97010); Procedures - Therapeutic Exercise (2 units) (97110), Neuromuscular Re-education (97112),

Myofascial Release (97530) and Therapeutic Activity (97530); Tests - Manual Muscle Testing (95831) and Reflex Testing.

30. The Respondent's documentation for the October 7, 1998 visit fails to support charging for 2 units of Therapeutic Exercise. The Respondent's documentation also does not support charging under either of the Test codes.

31. The Respondent treated Patient B on October 8, 1998. She noted the following charges for the visit: Procedures - Therapeutic Exercise (2 units) (97110), Myofascial Release (97250) and Therapeutic Activity (2 units) (97530).

32. The Respondent's documentation of the October 8, 1998 visit fails to support charging for 2 units of Therapeutic Activity or Therapeutic Exercise.

Patient C

33. Patient C, a female born in 1959, initially presented to Concentra on September 27, 1998 after jamming her left ring finger while playing basketball the previous day.

34. The Respondent treated Patient C on October 28, 1998. The Respondent's treatment plan includes modalities, therapeutic exercise, therapeutic activity and work conditioning; however, the Respondent failed to document the extent, if any, to which Patient C's injury disrupted her functional activities.

Patient D

35. Patient D, a female born in 1956, initially presented to Concentra on May 28, 1998 complaining of shoulder pain. Patient D reported that she sustained the work-related injury while reaching up to file in a tall filing cabinet. The Respondent's treatment plan includes Modalities, Therapeutic Exercise, Therapeutic Activity, Joint

Mobilization, MFR [myofascial release], work conditioning, postural re-education and work-station ergonomics.

36. The Respondent treated Patient D on June 1, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010), Electrical Stimulation (unattended) (97014) and Ultrasound (97035); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112) and Therapeutic Activity (97530); Tests - Manual Muscle Testing (95831) and Range of Motion (95851).

37. The Respondent's documentation for the June 1, 1998 visit fails to support charging under the Therapeutic Activity code or the test codes.

Patient E

38. Patient E, a female born in 1948, initially presented to Concentra on June 29, 1998 with a right thumb sprain. Patient E reported that she had injured her thumb in a work-related incident when she attempted to handcuff a prisoner.

39. Patient E was evaluated on June 28, 1998 by a PT student; the Respondent co-signed the evaluation. The student PT's treatment plan included therapeutic exercise, therapeutic activity and modalities.

40. The student PT treated Patient E on June 30, 1998 and the Respondent co-signed the student's notes. The notes indicate that Patient E performed 2 units of Therapeutic Exercise (97110) and 2 units to Therapeutic Activity (97530). The notes do not support charging for 2 units of these procedures.

41. The student PT treated Patient E on July 2, 1998; the Respondent co-signed the student's notes. The charges for the July 2, 1998 visit include: Modalities - Iontophoresis (97033); Procedures - Therapeutic Exercise (97110) and Therapeutic

Activity (97530); Tests - Manual Muscle Testing (95831), Range of Motion (95851), Girth Measurements (97799) and Jamar 1 (97750-0001).

42. The documentation of the July 2, 1998 visit fails to support charging under the Therapeutic Activity code or the Test codes.

43. The student PT treated Patient E on July 6, 1998; the Respondent co-signed the student's notes. The charges for the July 6, 1998 visit include: Modalities - Iontophoresis (97033); Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530); Tests - Girth Measurements (97799) and Jamar 1 (97750-0001).

44. The documentation of the July 6, 1998 visit fails to support charging under the Therapeutic Activity code or the Girth Measurement code.

45. The student PT treated Patient E on July 8, 1998; the Respondent co-signed the notes. The charges for the July 8, 1998 visit include: Procedures - Therapeutic Activity (97530) and Tests - Range of Motion - Hand (95852), Girth Measurements (97799) and Jamar 1 (97750-0001).

46. The documentation of the July 8, 1998 visit fails to support charging under the Test codes.

Patient F

47. Patient F, a male born in 1961, initially presented to Concentra on December 9, 1998 complaining of pain to his left shoulder. Patient F was evaluated and treated by a PT other than the Respondent for his first 3 visits.

48. The Respondent treated Patient F on December 14, 1998 and noted the following charges: Modalities - Hot/Cold Pack (97010), Electrical Stimulation (97014);

Procedures - Therapeutic Exercise (2 units) (97110) and Therapeutic Activity (2 units) (97530); Tests - Manual Muscle Testing (95831) and Range of Motion (95851).

49. The Respondent's documentation of the December 14, 1998 visit fails to support charging for 2 units of Therapeutic Exercise and Therapeutic Activity (97530), nor does it support charging under the Test codes.

50. The Respondent treated Patient F on December 16, 1998 and noted the following charges: Modalities - Hot/Cold Pack (97010), Electrical Stimulation (97014); Procedures - Therapeutic Exercise (2 units) (97110) and Therapeutic Activity (2 units) (97530).

51. The Respondent's documentation fails to support charging for 2 units of Therapeutic Activity and Therapeutic Exercise.

Patient G

52. Patient G, a female born in 1957, initially presented to Concentra on July 28, 1998 with a sprained left ankle. Patient G reported that she sustained the work-related injury on July 27, 1998 when she was stepping out of a van and twisted her ankle. The Respondent initially evaluated Patient G. Her treatment plan included modalities, manual therapy and work conditioning.

53. The Respondent treated Patient G on July 30, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Pack (97010), Electrical Stimulation (97014); Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530).

54. The Respondent's documentation of the July 30, 1998 visit fails to support charging under the Therapeutic Activity code.

55. The Respondent treated Patient G on July 31, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010), Electrical Stimulation and Ultrasound; Procedures - Therapeutic Exercise (97110), Therapeutic Activity (97530) and Joint Mobilization (97530); and Tests - Range of Motion (95851) and Girth Measurements (97799).

56. The Respondent's documentation of the July 31, 1998 visit fails to support charging under the Therapeutic Activity code or the Test codes. The Respondent performed Joint Mobilization in the absence of an assessment.

57. The Respondent treated Patient G on August 3, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Pack (97010), Electrical Stimulation (97014); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112), Joint Mobilization (97265) and Therapeutic Activity (97530).

58. The Respondent's documentation of the August 3, 1998 visit fails to support charging under the Therapeutic Activity code. In addition, the Respondent performed Joint Mobilizations without an assessment.

59. The Respondent treated Patient G on August 6, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Pack (97010), Electrical Stimulation (97014); Procedures - Therapeutic Exercise (2 units) (97110) and Therapeutic Activity (2 units) (97530); and Tests - Range of Motion (95851) and Girth Measurements (97799).

60. The Respondent's documentation of the August 6, 1998 visit fails to support charging under the Therapeutic Exercise or Therapeutic Activity codes, nor does it support charging under the Test codes.

61. The Respondent treated Patient G on August 10, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical Stimulation (97041); Procedures - Therapeutic Activity (97530) and Therapeutic Exercise (97110).

62. The Respondent's documentation of the August 10, 1998 visit fails to support charging for 2 units of Therapeutic Exercise or Therapeutic Activity.

63. A PTA treated Patient G on August 11, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Iontophoresis (97033); Procedures - Therapeutic Exercise (97110) (2 units) and Therapeutic Activity (97530) (2 units); and Tests - Range of Motion (95851) and Girth Measurements (97799). The PTA's documentation failed to support charging for 2 units of Therapeutic Activity and Therapeutic Exercise. The Respondent, by permitting the PTA to charge under the Test code 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.

64. The Respondent treated Patient G on August 13, 1998 and noted the following charges for that visit: Modalities - Hot/Cold Packs (97010); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112), Joint Mobilization (97264) and Therapeutic Activity (2 units) (97530).

65. The Respondent's documentation of the August 13, 1998 visits fails to support charging under the Therapeutic Activity code for either single or multiple units.

66. The Respondent was interviewed by the Board during its investigation of this case. The Respondent's explanation of the difference between Therapeutic Exercise and Therapeutic Activity does not reflect the accepted and published definition

of those terms. The Respondent acknowledged that she had failed to co-sign the student PT's notes of Patient A's treatment. She stated that the PTA verbally communicated to her the objective findings used in the assessment of Patient B and acknowledged that she (the Respondent) did not co-sign the progress note. The Respondent's statements with regard to the codes for which she is alleged herein to have failed to provide adequate documentation likewise failed to support the use of those codes.

67. The Respondent's conduct as set forth above, in whole or in part, constitutes violations of the Act and the regulations hereunder.

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 16th day of March, 2004, 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, which probation shall commence on the date the Respondent appears to take the Board-approved law course and which shall be subject to the following conditions:

1. Within one year of signing the Consent Order, the Respondent shall take

the Board-approved law and ethics course and pass the associated examination administered by the Board;

2. The Respondent shall successfully complete a Board-approved billing course. The course may be an on-line course; however, it must be pre-approved by the Board;

3. The Respondent shall successfully complete a Board-approved documentation course. The course may be an on-line course; however, it must be pre-approved by the Board;

4. 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.

3/16/04
Date

Margery F. Rodgers P.T.
~~Penelope D. Leecher, M.A., P.T., M.C.S.P., Chair~~
State Board of Physical Therapy Examiners
Margery F. Rodgers, P.T., Chair

CONSENT

I, Linda Eckert Ots, 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;

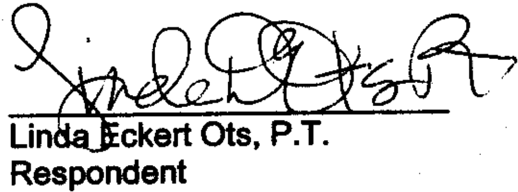
4. By this Consent Order, I hereby consent and submit to the foregoing Findings of Fact, Conclusions of Law and Order, provided the Board adopts the foregoing Consent Order in its entirety. I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary 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 considered 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.



2/19/04
Date

Linda Eckert Ots, P.T.
Respondent

Bosnia and Herzegovina (
Canton of Sarajevo (
City of Sarajevo (SS:
Embassy of the United States of America (
Bosnia and Herzegovina (

STATE OF: ______

CITY/COUNTY OF: ______

I HEREBY CERTIFY that on this 19TH day of FEB, 2004, before me, a U.S. CONSULAR ASSOCIATE ~~Notary~~ of the State of ______ and the City/County of BOSNIA AND HERZEGOVINA personally appeared Linda Eckert Ots 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.

Vonda K. Wolcott
Consular Associate