IN THE MATTER OF	*	**BEFORE THE MARYLAND**
RANDI M. POTLER, P.T.	*	**STATE BOARD OF**
Respondent	*	**PHYSICAL THERAPY EXAMINERS**
License Number: 20680	*	**Case Numbers: 07-22 & 08-21**

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CONSENT ORDER

The Maryland State Board of Physical Therapy Examiners (the "Board") charged **RANDI M. POTLER, P.T. (the "Respondent") License Number 20680**, with violations of certain provisions of the Maryland Physical Therapy Act, (the "Act") codified at Md. Health Occ. Code Ann. ("H.O.") §§ 13-101 *et seq.* (2005 Repl. Vol.).

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, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee, or holder:
>
> (15) Violates any provision of this title or rule or regulation adopted by the Board;
>
> (25) Fails to meet accepted standards in delivering physical therapy or limited physical therapy care.

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

A. Physical Therapists.

(2) The physical therapist shall:

(a) Exercise sound professional judgment in the use of evaluation and treatment procedures;
(e) Evaluate the patient and develop a plan of care before the patient is treated;
(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 charged the Respondent with the following violations of Code Md. Regs. tit. 10, § 38.03.02-1 Requirements for Documentation:

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

(1) The initial visit, by including the following information:

(a) Date;
(b) Condition, or diagnosis, or both, 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) Modalities, or procedures, or both, used during the initial visit and the parameters involved including the areas of the body treated;
(i) Plan of care including suggested modalities, or procedures, or both, number of visits per week, and number of weeks; and
(j) Signature, title (PT), and license number.

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

(k) Date;
(l) Cancellations, no-shows;
(m) Subjective response to previous treatment;
(n) Modalities, or procedures, or both, with any changes in the parameters involved and areas of body treated;
(o) Objective functional status;
(p) Response to current treatment;

(q) Continuation of or changes in plan of care; and
(r) Signature, title (PT), and license number, although the flow chart may be initialed.

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

(a) Date;
(b) Number of treatments;
(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) Plan of care including recommendations for follow-up; and
(i) Signature, title (PT), and license number;

On Tuesday, October 7, 2008, the Respondent appeared with counsel before the Case Resolution Conference Committee (the "CRC") of the Board. As a result of the negotiation that occurred prior to and at the CRC, the Respondent agreed to enter into this Consent Order, consisting of the Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. At all times relevant to these charges, the Respondent was and is a physical therapist licensed to practice physical therapy in the State of Maryland. She was originally licensed to practice physical therapy in Maryland on or about August 21, 2002, under license number 20680.

2. At all times relevant to these charges, the Respondent was a staff physical therapist at Life Fitness Physical Therapy of Towson, LLC ("Life Fitness"), a limited liability company organized under the laws of the State of Maryland and located at 1205 York Road, Suite 19, Lutherville, Maryland 21093.

3. At all times relevant to these charges, Physical Therapist A,[1] the sole member and owner of Life Fitness, employed the Respondent and Staff Therapist 1 as staff physical therapists at Life Fitness.

4. On or about February 12, 2007, the Board initiated an investigation of the Physical Therapist A and Life Fitness after receiving a complaint from a utilization reviewer alleging that Physical Therapist A failed to meet accepted standards in delivering physical therapy care with respect to a patient at Life Fitness ("Patient A") whose charts Physical Therapist A had submitted to the utilization reviewer for review.

5. On or about August 28, 2007, the Board received a second complaint from the same utilization reviewer alleging that the Respondent and Staff Therapist 1 failed to meet accepted standards in delivering physical therapy care with respect to a another patient at Life Fitness ("Patient B") whose charts Physical Therapist A had submitted to the utilization reviewer for review.[2]

6. In furtherance of its investigation, the Board staff interviewed the utilization reviewer, Patient A, Patient B, Staff Therapist 1, Physical Therapist A, and the Respondent. The Board subpoenaed records of Patient A and Patient B from Physical Therapist A, which were independently reviewed by a physical therapist retained by the Board for this purpose.

7. Subsequent to being notified of the Board's investigation, the Respondent voluntarily took the following corrective actions: 1) completed the Maryland law and ethics course; and 2) instituted peer review policies in her practice.

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[1] To ensure confidentiality, individual names will not be disclosed in this document. The Respondent may obtain the identity of all individuals referenced in this document by contacting the administrative prosecutor.

[2] The Board also voted to charge Physical Therapist A and Staff Therapist 1 with violations of the Act stemming from the February 12 and August 28, 2007, complaints.

8. The Board's investigative findings are set forth *infra*.

Patient A

9. Patient A, a male born in 1955, presented to Life Fitness on or about December 13, 2006, with a referral from a physician for physical therapy consultation with respect to his initial diagnosis of cervical and lumbar sprain/strain, and lateral epicondylitis that resulted from a job-related motor vehicle accident. The physician also prescribed Dexamethasone[3] for iontophoresis[4] treatment of Patient A's elbow.

10. Physical Therapist A conducted the initial evaluation of Patient A and was primarily responsible for the care and treatment of Patient A. On numerous occasions, however, Physical Therapist A delegated the care and treatment of Patient A to the Respondent.

11. The Respondent treated Patient A on the following dates: January 9, 2007, January 23, 2007, March 23, 2007, April 9, 2007, April 11, 2007, April 13, 2007, and April 25, 2007.

12. During Patient A's first visit with the Respondent on January 9, 2007, the Respondent failed to evaluate Patient A and develop a plan of care before treating Patient A. The Respondent knew or should have known that Physical Therapist A's plan of care for Patient A in the initial evaluation was inadequate in that it was pre-written and not unique or specific for Patient A. Therefore, the Respondent was required to evaluate and develop an appropriate plan of care unique or specific to Patient A before treating him, which the Respondent failed to do.

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[3] Dexamethasone is an anti-inflammatory corticosteroid.
[4] Iontophoresis is the use of an electric current to introduce the ions of medicine into the tissue.

13. The Respondent's daily treatment notes for the dates she treated Patient A were inadequate in that they were devoid of any details as to the daily encounter, response and progression of treatment involving Patient A, and were essentially billing records with check-offs of CPT codes.[5] The Respondent failed to note in sufficient details the subjective response from Patient A to previous treatments on the following dates: 1/23/07, 3/23/07, 4/9/07, 4/11/07, and 4/25/07. The Respondent's checking off of CPT codes failed to provide details as to the modalities or procedures performed, as well as the parameters involved and areas of body treated. Furthermore, the Respondent failed to note in the daily treatment notes Patient A's objective functional status and failed to provide sufficient details as Patient A's response to current treatment. Finally, the Respondent checked off "Treatment as per Flow Sheet," when there was no evidence as to the existence of any "Flow Sheet" for Patient A.

14. The Respondent failed to reevaluate Patient A at least every 30 days. Subsequent to the initial evaluation on December 13, 2006, reevaluations were done by Physical Therapist A on January 15, 2007, February 5, 2007, and April 18, 2007. Although the patient charts indicated that Patient A had not been evaluated within 30 days subsequent to his reevaluation by Physical Therapist A on February 5, 2007, the Respondent failed to reevaluate Patient A when she treated him on March 23, 2007, and failed to document any rationale for not performing the reevaluation within the time period.

[5] The acronym "CPT" is the abbreviation for Current Procedural Terminology. CPT codes provide a uniform language that reflects medical, surgical and diagnostic procedures and is extensively used in the processing of health care claims.

15. During the investigation, the Board discovered that the Respondent, as well as Physical Therapist A and Staff Therapist 1 administered the prescription drug, Dexamethasone through the use of iontophoresis treatment to patients by drawing the medication indiscriminately from a bulk source stored at the facility. The bulk source was a commingling of the same medications without labels from different patients who kept their prescribed medication at the facility. During an interview conducted by the Board Investigator on September 13, 2007, the Respondent admitted to the practice described above.

16. Furthermore, the Respondent failed to document in the daily treatment notes that Patient A received iontophoresis treatments during his visits.

17. The Respondent's actions, including but not limited to, failure to appropriately store, administer, and document the administering of patients' prescription drug, constitute, in whole or in part, failure to meet accepted standards in delivering physical therapy care, in violation of H.O. § 13-316(25); and/or violation of regulations adopted by the Board, in violation of H.O. § 13-316(15); specifically, failure to exercise sound professional judgment in the use of evaluations and treatment procedures, in violation of the Board's Standard of Practice, Code Md. Regs. tit. 10, § 38.03.02A(2)(a), and/or failure to meet the requirements for documentation, in violation of Code Md. Regs. tit. 10, § 38.03.02-1.

18. The Respondent's actions, including but not limited to: failure to adequately perform and/or adequately document the performance of daily treatments; and failure to adequately develop and/or adequately document the development of a plan of care, constitute, in whole or in part, failure to meet accepted standards in

delivering physical therapy care, in violation of H.O. § 13-316(25); and/or violation of regulations adopted by the Board, in violation of H.O. § 13-316(15); specifically, failure to exercise sound professional judgment in the use of evaluations and treatment procedures, in violation of the Board's Standard of Practice, Code Md. Regs. tit. 10, § 38.03.02A(2)(a); failure to evaluate the patient and develop a plan of care before the patient is treated, in violation of Code Md. Regs. tit. 10, § 38.03.02A(2)(e); and/or failure to meet the requirements for documentation, in violation of Code Md. Regs. tit. 10, § 38.03.02-1.

19. The Respondent's actions, including but not limited to, failure to reevaluate Patient A at least every 30 days, constitute, in whole or in part, failure to meet accepted standards in delivering physical therapy care, in violation of H.O. § 13-316(25); and/or violation of regulations adopted by the Board, in violation of H.O. § 13-316(15); specifically, failure to 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, in violation of Code Md. Regs. tit. 10, § 38.03.02A(2)(g).

Patient B

20. Patient B, a female born in 1944, presented to Life Fitness on or about May 21, 2007, status post cervical fusion C2-C3 and C5-C6 after a work related injury on March 1, 2007 that resulted in a cervical vertebral fracture.

21. Staff Therapist 1 did the initial evaluation and was primarily responsible for the care and treatment of Patient B. On numerous occasions, however, Staff Therapist 1 delegated the treatment and care of Patient B to the Respondent.

22. The Respondent treated Patient B on the following dates: May 25, 2007, July 24, 2007, July 30, 2007, July 31, 2007, August 7, 2007, August 13, 2007, August 14, 2007, and August 29, 2007.

23. During Patient B's first visit with the Respondent on May 25, 2007, the Respondent failed to evaluate Patient B and develop a plan of care before treating Patient B. The Respondent knew or should have known that Staff Therapist 1's plan of care for Patient B in the initial evaluation was inadequate in that it was pre-written and not unique or specific for Patient B. Therefore, the Respondent was required to evaluate and develop an appropriate plan of care unique or specific to Patient B before treating her, which the Respondent failed to do.

24. With respect to her treatments of Patient B on May 25, 2007, and July 24, 2007, the Respondent's daily treatment notes were inadequate in that they were devoid of any details as to the daily encounter, response and progression of treatment involving Patient B, and were essentially billing records with check-offs of CPT codes. The Respondent failed to note in sufficient details on May 25, 2007, the subjective response from Patient B to previous treatment. The Respondent's checking off of CPT codes failed to provide details as to the modalities or procedures performed, as well as the parameters involved and areas of body treated. Furthermore, the Respondent failed to note in the daily treatment notes Patient B's objective functional status and failed to provide in sufficient detail Patient B's response to current treatment. Finally, in the July

24, 2007, daily treatment notes, the Respondent checked off "Treatment as per Flow Sheet," when there was no evidence as to the existence of "Flow Sheet" for Patient B for that date.

25. The Respondent's daily treatment notes for Patient B from July 20, 2007, and thereafter consisted of 3 types of documents: 1) CPT codes; 2) SOAP notes; and 3) treatment flow sheet.

26. The Respondent's checking off of CPT codes failed to provide sufficient details as to the modalities or procedures performed, as well as the parameters involved and areas of body treated. Furthermore, the Respondent failed to note in the daily treatment notes Patient B's objective functional status and failed to provide sufficient details as to Patient B's response to current treatment.

27. The Respondent's actions, including but not limited to: failure to adequately perform and/or adequately document the performance of daily treatment' and failure to adequately develop and/or adequately document the development of a plan of care, constitute, in whole or in part, failure to meet accepted standards in delivering physical therapy care, in violation of H.O. § 13-316(25); and/or violation of regulations adopted by the Board, in violation of H.O. § 13-316(15); specifically, failure to exercise sound professional judgment in the use of evaluations and treatment procedures, in violation of the Board's Standard of Practice, Code Md. Regs. tit. 10, § 38.03.02A(2)(a); failure to evaluate the patient and develop a plan of care before the patient is treated, in violation of Code Md. Regs. tit. 10, § 38.03.02A(2)(e); and/or failure to meet the requirements for documentation, in violation of Code Md. Regs. tit. 10, § 38.03.02-1.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent violated Md. Health Occ. Code Ann. § 13-316(15), § 13-316(25) and Code Md. Regs. tit. 10, § 38.03.02A(2)(a), § 38.03.02A(2)(e), § 38.03.02A(2)(g) and § 38.03.02-1A.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 16th day of ~~October~~ December, 2008, by a majority of the Board considering this case:

ORDERED that the Respondent's license to practice physical therapy in the State of Maryland shall be **REPRIMANDED**; and be it further

ORDERED that the Respondent shall be placed on **PROBATION** for a **PERIOD OF TWO (2) YEARS** for the violations stated herein, to commence from the date of the execution of this Consent Order, subject to the following terms and conditions:

1. The Respondent shall enroll in and successfully complete a comprehensive Board-approved course in documentation within the first year of probation, with credit, to be given at the Board's discretion, for documentation course(s) already taken as a result of the investigation in the instant case;
2. The courses outlined in paragraphs one (1) shall be in addition to any Continuing Education requirements mandated for continuing certification as a physical therapist, and shall not count toward fulfilling any licensure requirements that the Respondent must fulfill in order to renew her physical therapist license;

3. The Respondent shall be required to submit three (3) treatment records to the Board for review on a quarterly basis (every three months) for the duration of the **TWO YEAR** probationary period as follows:

a) The first due date for submission of the treatment records to the Board shall be on or before three months from the date of the execution of this Consent Order. The subsequent due dates for the submission of the treatment records shall be on or before the last date of each corresponding quarter. Thus, the due date for the second submission of treatment records shall be six months from the date of this Consent Order. The treatment records submitted for each quarter shall be randomly selected by the Respondent and shall reflect treatments rendered primarily by the Respondent during that quarter;

b) The Board shall review all aspects of the Respondent's documentation and treatment;

c) The Respondent shall provide to the Board the complete record for each patient whose records are to be reviewed;

d) The Respondent shall comply with all written recommendations made by the Board following its quarterly review of his treatment records. The Respondent's failure to comply with the Board's written recommendation shall be deemed a violation of this Consent Order;

e) The Respondent's failure to submit the quarterly treatment records on or before the due dates outlined in paragraph 3(a) shall be deemed a violation of this Consent Order.

4. The Respondent shall pay a monetary fine in the amount of one thousand dollars ($1,000) by certified check or money order made payable to the Maryland State Board of Physical Therapy Examiners no later than six (6) months from the date of the execution of this Consent Order.

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

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

ORDERED after the conclusion of the entire **TWO (2) YEAR** period of **PROBATION**, the Respondent may file a written petition for termination of her probationary status without further conditions or restrictions, but only if the Respondent has satisfactorily complied with all conditions of this Consent Order, including all terms and conditions of probation, and including the expiration of the two year period of probation, and if there are no pending complaints regarding the Respondent before the Board; and be it further

ORDERED that should the Respondent violate any of the terms and conditions of this Consent Order, the Board, after notice and an opportunity for a hearing and determination of violation, may impose any other disciplinary sanctions it deems appropriate, including suspension or revocation, said violation being proven by a preponderance of the evidence; and be it further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. §§ 10-611 *et seq.* (2004 Repl. Vol.).

Margery F Rodgers, P.T.

Margery Rodgers, P.T., Chair
State Board of Physical Therapy Examiners

CONSENT OF RANDI M. POTLER, P.T.

I, Randi M. Potler, P.T., License Number 20680, by affixing my signature hereto, acknowledge that:

1. I have had the opportunity to consult with counsel before signing this Consent Order;

2. I am aware that I am entitled to a formal evidentiary hearing before the Board, pursuant to Md. Health Occ. Code Ann. § 13-317 (2005 Repl. Vol.) and Md. State Gov't Code Ann. §§ 10-201 *et seq.* (2004 Repl. Vol.).

3. I acknowledge the validity and enforceability of this Consent Order as if entered into after 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 to which I am entitled by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into the foregoing Findings of Fact, Conclusions of Law and Order, and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law, and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

5. I acknowledge that by failing to abide by the conditions set forth in this Consent Order, I may be subject to disciplinary actions, which may include revocation of my license to practice physical therapy.

6. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

12/11/08
Date

Randi Potler PT
Randi M. Potler, P.T.

STATE OF MARYLAND

~~CITY~~/**COUNTY OF** Harford:

I HEREBY CERTIFY that on this 11th day of December, 2008, before me, Christina L. Canatella a Notary Public of the foregoing State and ~~city~~/county, personally appeared Randi M. Potler, P.T., License Number 20680, and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed, and the statements made herein are true and correct.

AS WITNESSETH my hand and notary seal.

Christina L Canatella
Notary Public

My Commission Expires: CHRISTINA L. CANATELLA NOTARY PUBLIC HARFORD COUNTY MARYLAND MY COMMISSION EXPIRES 11/18/2011