DOCKET NO. 453-03-0928.M5
[MDR TRACKING NO. M5-02-2041-01]

ZURICH AMERICAN INSURANCE COMPANY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
VS.	§	**OF**
	§	
SUHAIL S. AL-SAHLI, D.C.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case is a dispute over whether reimbursement is appropriate for treatment rendered to___ (Claimant) by Suhail S. Al-Sahli, D.C. (Provider), between January 29, 2001, and July 6, 2001. Provider sought reimbursement from Zurich American Insurance Company (Carrier) in the amount of $899 for treatment rendered to___, which Carrier denied. The Texas Workers' Compensation Commission (the Commission) Medical Review Division (MRD) adopted the findings of the Independent Review Organization (IRO) that held Provider was entitled to full reimbursement. In this Order, the Administrative Law Judge (ALJ) concludes Provider is not entitled to any reimbursement.

I.
JURISDICTION, NOTICE AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Therefore, those matters will be addressed in the findings of facts and conclusions of law without further discussion here. Provider appealed the findings and decision of the IRO, which was set out in MRD docket number M5-02-2041-01, issued on September 5, 2002.

A hearing convened and closed on March 25, 2003, before the State Office of Administrative Hearings (SOAH) with Steven M. Rivas, ALJ, presiding. Carrier appeared and was represented by Steve Tipton, attorney. Provider appeared and represented himself.

II.
DISCUSSION

1. Background Facts

On_____, Claimant sustained a compensable neck and shoulder injury when her arm got caught in a bagging machine. One month following the injury, Provider diagnosed Claimant with musculoskeletal injuries and referred Claimant to Moshe Allon, M.D. On April 1, 2000, Dr. Allon recommended and performed arthroscopic surgery on Clamant's shoulder and found no significant injury to Claimant's shoulder. Dr. Allon documented a "good result," and recommended Claimant undergo a course of physical therapy under Provider. Provider administered various treatments and procedures to Claimant between January 29, 2001, and July 7, 2001. Carrier denied reimbursement for the services as not medically necessary.

B. Applicable Law

The Texas Labor Code contains the Texas Workers' Compensation Act (the Act) and provides the relevant statutory requirements regarding compensable treatment for workers' compensation claims. In particular, the Act, as noted in § 408.021, provides an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Under the same statute, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

3. IRO Decision

This dispute was referred to an IRO, which found the treatment rendered to Claimant was medically necessary. As its rationale, the reviewer stated, "it appears that the Claimant was clearly continuing to experience difficulties, and the treating doctor (Provider) was attempting to promote recovery according to TWCC guidelines utilizing conservative treatment measures."

4. Evidence and Arguments

1. Treatment in question

The treatment consisted of 17 separate procedures performed over 13 visits between the disputed dates of service. On each visit, Provider billed for CPT code 99213. In addition to 99213, Provider billed for CPT code 97110 on two visits. On one visit, March 28, 2002, Provider billed for CPT codes 97250 and 97035, in addition to 97110 and 99213.

The CPT codes are defined in the Commission's Medical Fee Guideline (MFG), which the Commission adopted and became effective April 1, 1996.[1]

Code 99213 is defined as an office visit for the evaluation and management of an established patient. Each visit should include at least two of the following components: an examination of the patient's medical history, an examination of the patient's medical condition and symptoms, and/or a prognosis on how the patient's treatment plan.

Code 97110 consists of a 15-minute therapeutic exercise to develop strength and endurance, range of motion and flexibility. Code 97250 is a myofascial release/soft tissue mobilization, andcode 97035 is an ultrasound.[2]

2. Carrier

Carrier argued the treatment rendered to Claimant on the disputed dates of service did nothing more than perpetuate Claimant's exaggeration of symptoms. Carrier does not dispute the initial treatment that was rendered to Claimant following her arthroscopic surgery in April of 2000.[3]

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[1] 28 TEX. ADMIN. CODE § 134.201(a).

[2] *See Id.*

[3] Claimant began post-surgery treatment with Provider on May 3, 2000, and received eight months of treatment before the dates of service of this dispute began.

However, Carrier argued, the ongoing treatment following the initial eight months of treatment was not medically necessary considering no significant findings were reported from the arthroscopic surgery.

Carrier offered three medical reports in support of its position. The first was done by Bill W. Timberlake, D.C., dated November 22, 2000. In that report Dr. Timberlake referred to an examination that was performed by the Commission's designated doctor, Gregory Woordward, D.C., on July 7, 2000. Based on Dr. Woodward's examination, Claimant had not reached maximum medical improvement (MMI). Dr. Woodward also recommended additional range of motion and strengthening exercises. However, Dr. Timberlake asserted, even taking into consideration Dr. Woodward's report, there was "no reasonable necessity established for continued treatment beyond an eight week period following July 7, 2000." In other words, Claimant required treatment following the surgery, but that treatment should not continue after September 2000.

The next report was done by Lloyd Payne, D.C., dated October 3, 2002. Dr. Payne noted Claimant underwent an MRI on August 15, 2000, which revealed a Grade I tear that had worsened since previous study. Dr. Payne also noted Claimant underwent a functional capacity evaluation (FCE) in September 2000, which resulted in a work hardening recommendation. According to Dr. Payne, Claimant completed four weeks of work hardening, and then underwent a required (?) medical examination (RME) with James Hood, M.D. Dr. Hood recommended another MRI of Claimant's left shoulder, but the results of this MRI were not noted in Dr. Payne's report. Dr. Payne found the Claimant should have obtained "maximum therapeutic benefit" from the chiropractic treatment at the conclusion of the post surgical rehabilitation and/or work hardening. Additionally, Dr. Payne asserted, "the ongoing treatment in this case has likely served to foster treatment dependence, chronicity, and somatization."

Finally, Carrier presented a report from Theodore Pearlman, M.D., dated October 3, 2002. Dr. Pearlman noted Claimant's medical history similar to what Dr. Timberlake and Dr. Payne documented. Dr. Pearlman also asserted "six weeks of physical and chiropractic treatment following arthroscopy was reasonable." Dr. Pearlman also stated all treatment following the six weeks of treatment was unnecessary and "served to foster (Claimant's) symptom exaggeration."

3. Provider

Provider argued the treatment rendered to Claimant was done under the Act § 408.021(a), in that Claimant found relief from her pain by being treated by Provider. In support of its position, Provider offered progress notes and office visit notes for the dates of service in dispute. Some of the notes were handwritten and a few visits were not documented.[4] Each note outlines Claimant's

[4] Provider had no record of office visits for February 26, March 5, and May 2, 2001.

complaints of pain and other symptoms. The notes also identify the type of treatment that was rendered and recommends "patient should return three times weekly."

Provider did not address the reports offered by Carrier. Provider argued, despite the lack of documentation, Claimant received some benefit as a result of the treatment rendered by Provider and should be reimbursed.

Provider further asserted the IRO decision was correct in finding the treatment rendered to Claimant was medically necessary.

5. Analysis and Conclusion

The documentation presented by Provider clearly does not reflect Claimant experienced any relief from Provider's treatment. Under the Act § 408.021(a), an employee is entitled to all health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

The ALJ was not persuaded by Provider's evidence, which merely reflected that Claimant made several office visits. The procedures administered to Claimant were noted in Provider's documents, but there was no mention that any of the treatment was actually curing or relieving Claimant of the effects of the injury. After reviewing Provider's evidence, the ALJ is required to infer Claimant received some relief from the pain associated with her injury because this information was not documented. Additionally, there was no documentation that the treatment promoted recovery or enhanced Claimant's ability to obtain employment.

The IRO decision stated in its opinion that Clamant was "continuing to experience difficulties, and the treating doctor (Provider) was attempting to promote recovery." Carrier argued this rationale is not the appropriate standard in determining whether Claimant is entitled to health care. The ALJ agrees and is not sure whether the IRO reviewer considered Claimant's "difficulties" were a result of the injury. Additionally, Provider's "attempt" to promote recovery is also not proper under the statute. The ALJ understands the IRO reviewer's assertion that Provider was "attempting to promote recovery" because Provider's documentation gave no indication regarding Claimant's recovery. However, Carrier is correct in that Provider presented no evidence to the IRO or this ALJ that the treatment rendered to Claimant promoted any recovery as outlined in the statute.

Based on the evidence presented at the hearing, the ALJ believes the treatment rendered to Claimant over the disputed dates of service was not medically necessary because there was no (or insufficient) evidence presented that the treatment was rendered in accordance with the Act ' 408.021(a).

III.
FINDINGS OF FACT

1. Claimant ___ suffered a compensable neck and shoulder injury on_____.

2. Claimant initially came under the care of Suhail Al-Sahli, D.C. (Provider), who referred Claimant to Moshe Allon, M.D.

3. Dr. Allon performed arthroscopic surgery on Claimant on April 1, 2000, which revealed no significant findings.

4. Following the arthroscopic surgery, Dr. Allon prescribed physical therapy with Provider.

5. Provider began treating Claimant on May 3, 2000, and rendered treatment through July 2001.

6. Provider billed Zurich American Insurance Company (Carrier) $899 for the treatment it rendered to Claimant from January 29, 2001, and July 6, 2001, which Carrier denied as not medically necessary.

7. Provider filed a Request for Medical Review Dispute Resolution with the Texas Workers' Compensation Commission (the Commission), seeking reimbursement for the treatment rendered to Claimant.

8. The dispute was referred to an Independent Review Organization (IRO), which found Provider was entitled to full reimbursement for the treatment it rendered to Claimant from January 29, 2001, through July 6, 2001.

9. The Commission's Medical Review Division (MRD) in docket number M5-02-2041-01 adopted the IRO decision in its findings and decision issued on September 5, 2002.

10. Carrier timely appealed the IRO decision and filed a request for hearing before the State Office of Administrative Hearings (SOAH) seeking denial of reimbursement to Provider.

11. Notice of the hearing was sent November 1, 2002.

12. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

13. The hearing convened and closed on March 25, 2003, with Steven M. Rivas, Administrative Law Judge (ALJ) presiding. Carrier appeared and was represented by Steve Tipton, attorney. Provider appeared and represented himself.

14. Provider administered eight months of treatment to Claimant before Carrier began to deny reimbursement.

15. Claimant's ongoing treatment perpetuated her exaggeration of symptoms.

16. Provider presented insufficient evidence that the treatment rendered to Claimant promoted any recovery of Claimant's injury.

IV.
CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to Section 413.031 of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. ch. 401 *et seq*.

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

3. Provider timely filed its request for hearing as specified by 28 TEX. ADMIN. CODE §148.3.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. § 2001.052 and 28 TEX. ADMIN. CODE § 148.4.

5. The Carrier, as Petitioner, has the burden of proof in this matter under 28 TEX. ADMIN. CODE §148.21(h).

6. Under TEX. LAB. CODE ANN. §408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment..

7. Provider has failed to show, by a preponderance of the evidence, that the treatment Provider rendered to Claimant was medically necessary for the dates in dispute.

8. Pursuant to the foregoing Findings of Fact and Conclusions of Law, Provider is not entitled to any reimbursement for the treatment it rendered to Claimant.

ORDER

IT IS, THEREFORE, ORDERED that Provider, Suhail Al-Sahli, D.C., is not entitled to receive any reimbursement from the Carrier, Zurich American Insurance Company, for the treatment it rendered to Claimant from January 29, 2001, through July 6, 2001.

Signed this 13th day of May, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

_____

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE