SOAH DOCKET NO. 453-04-0661.M5
TWCC MR NO. M5-03-2836-01

CENTRAL DALLAS REHAB,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
AMERICAN HOME ASSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. DISCUSSION

Central Dallas Rehab (Petitioner) sought reimbursement from American Home Assurance Company (Respondent) for work hardening, office visits, treatments and physician conferences from March 25, 2003, through May 19, 2003, provided to ___ (Claimant). Respondent contended that the services were not medically reasonable or necessary. An Independent Review Organization (IRO) agreed with Respondent and issued a decision denying the requested reimbursement.

The amount in dispute is $2302.40. After considering the evidence and arguments of the parties, the Administrative Law Judge (ALJ) denies the relief sought by Petitioner.

The hearing convened on February 12, 2004, with State Office of Administrative Hearings (SOAH) ALJ Howard S. Seitzman presiding. Petitioner was represented by Scott Hilliard and Respondent appeared through its counsel, Jane Lipscomb Stone. Ted Krejci, D.C., testified for Petitioner and Samuel M. Bierner, M.D., testified for Respondent. The hearing concluded and the record closed that day. Neither party objected to notice or jurisdiction.

Claimant suffered a work-related injury to his back on or about ___. On ___, Claimant was examined by David Zahaluk, M.D., who diagnosed sciatica and returned Claimant to work with certain restrictions. Dr. Zahaluk also prescribed several medications for Claimant.

Thereafter, Claimant underwent a lengthy series of examinations, tests and treatments not fully chronicled in this discussion. The records do reflect a variety of diagnoses from a variety of healthcare providers. Many of the diagnoses find no support in the contemporary medical records.

The medical evidence is replete with contrary findings regarding Claimant's physical and mental status. For example, work hardening began on February 2, 2003, and continued through April 2, 2003. The progress notes throughout the work hardening sessions are substantially similar and almost always note that the Claimant is improving and participating more as his pain decreases. In sharp contrast to the work hardening notes, on February 12, 2003, Petitioner's staffing note indicated Claimant was referred to a neurosurgeon to determine the appropriateness of the work hardening and other therapy because his low back pain was increasing. A February 17, 2003 staffing note mentioned that Claimant's pain medication was "not helping much."

Beginning March 21, 2003, the work hardening notes also reflected that Claimant was much improved and that Dr. Krejci and Claimant were quite happy with the progress. However, on March 26, 2003, Claimant visited Neil J. Atlin, D.O., who indicated that Claimant had become progressively despondent and depressed. On May 30, 2003, Patsy C. McNatt, a licensed professional counselor, wrote that Claimant's opinion was that his condition had deteriorated since the date of injury.

While certain examiners found Claimant's lumbar range of motion to be normal, others find it diminished. While certain examiners found improvement, others found no progress. The May 30, 2003 Pain Mental Health Evaluation by Patsy C. McNatt noted (1) numerous inconsistencies in Claimant's self-reporting, testing and observed performance; and (2) that Claimant's pain was not severe enough to present an obstacle to his improvement in functioning capabilities, including those required for return to work.

The issue in this proceeding is whether the work hardening and office visits services provided by Petitioner to Claimant from March 25, 2003, through May 19, 2003, were medically necessary. Petitioner had the burden of proof. Petitioner failed to prove that the services were medically necessary. The records reflect a witches' brew of diagnoses, but the credible medical evidence

supports only a lumbar sprain/strain. Petitioner's progress notes report improvement, but the FCE results and the medical records do not reflect improvement in Claimant's symptomology or contentment by Claimant with an improving condition. The credible evidence finds an individual with symptom magnification who became more depressed because he believed his condition was essentially unchanged or deteriorating.

Preauthorization for work hardening was denied in the latter part of 2002. Although preauthorization for work hardening was not required in February 2003, medical necessity was required. The credible medical evidence does not warrant a conclusion that on February 2, 2003, work hardening was medically necessary or reasonable. Claimant's condition appears to depend primarily on the examiner and the day. Even if work hardening had been medically necessary and reasonable on February 2, 2003, ten days later on February 12, 2003, Petitioner questioned whether it was appropriate to complete the program and referred Claimant to a neurosurgeon. Work hardening should have ceased at that juncture.

There is no demonstrated change in Claimant's physical condition or ability. Reliance upon the daily progress notes for the work hardening program is questionable at best, because while not identical, they are substantially similar and are not consistent with findings by other treating professionals or with the Claimant's own expressions. Of particular note is the contrast between Petitioner's work hardening notes from March 21, 2003, indicating Claimant was quite satisfied with his improvement and the March 26, 2003 notes of Dr. Atlin recording that Claimant had become progressively despondent and depressed. Claimant's continued lack of demonstrated improvement does not support a finding of medical necessity for completing the balance of the work hardening sessions.[1]

As to the office visits, treatments and physician conferences, there is no indication of improvement as evidenced by the progress notes. No consideration is given to altering or suspending the unsuccessful course of treatment. The only change made by Petitioner is the extension of

[1] In addition to the final work hardening session on April 1, 2003, at issue in this proceeding are the work hardening sessions of March 25, 26, 27, 28, and 31, 2003.

Claimant's anticipated release date. The office visits, treatments and physician conferences were not reasonable or necessary for treatment of Claimant or for patient management.

Petitioner failed to demonstrate by a preponderance of the evidence that the services it provided Claimant between March 25, 2003, through May 19, 2003, were medically necessary or reasonable. Petitioner is not entitled to reimbursement for services provided Claimant between March 25, 2003, through May 19, 2003.

II. FINDINGS OF FACT

1. ___ (Claimant) suffered a work related injury on ___.

2. On ___, Claimant was examined by David Zahaluk, M.D., who diagnosed sciatica and returned Claimant to work with certain restrictions.

3. On June 24, 2002, Dr. Zahaluk referred Claimant to Felix Segovia, M.D., an orthopedic surgeon.

4. Dr. Segovia examined Claimant on June 27, 2002, and diagnosed acute lumbrosacral sprain. At the time of the examination, Claimant experienced low back pain but no leg pain.

5. Dr. Segovia prescribed physical therapy.

6. Claimant visited Texas Rehab on July 3, 2002, and began receiving physical therapy.

7. On September 3, 2002 Dr. Segovia noted that Claimant exhibited symptom magnification.

8. A September 4, 2002 Functional Capacity Evaluation (FCE) showed Claimant was capable of light duty.

9. Claimant was identified as depressed, experiencing significant pain during task performance and having poor strength and cardiovascular endurance. A work hardening program was recommended.

10. Although finding Claimant's condition had improved, on September 24, 2002, Dr. Segovia prescribed a work hardening program for twenty days and Texas Rehab requested preauthorization for the work hardening program on September 27, 2002.

11. Two peer review analyses in October 2002, recommended denial of the work hardening program as not medically necessary.

12. Dorothy Leong, M.D., performed an independent medical assessment peer review on November 16, 2002. Dr. Leong concluded Claimant's subjective complaints far exceeded his objective clinical findings and, based upon the FCE, he was capable of light duty.

13. Dr. Leong invalidated Claimant's range of motion flexion and extension results because they did not satisfy the American Medical Association's validation criteria. Muscle strength was normal. The neurological examination showed decreased sensation to the entire right lower extremity.

14. Dr. Leong found Maximum Medical Improvement (MMI) as of September 3, 2002, and 5% whole person impairment.

15. On January 28, 2003, Ted Krejci, D.C., recommended a second FCE to determine whether Claimant was ready to return to work or ready for a work hardening program.

16. On January 30, 2003, Claimant underwent a second FCE. He again was cleared for light duty and his pain intensity was described as low moderate, 4/10. He was assessed as having significant mental stress. A work hardening program was recommended and ordered.

17. Work hardening began on February 2, 2003, and continued through April 1, 2003.

18. The progress notes throughout the work hardening sessions are substantially similar and almost always note that the Claimant is feeling slightly better, participating more as pain decreases slightly, and improving.

19. Beginning March 21, 2003, the work hardening progress notes also reflected that Claimant's improvement is significant enough to satisfy both the treating medical professional and Claimant.

20. On February 12, 2003, a staffing note indicated Claimant was referred to a neurosurgeon because his low back pain was increasing. The referral was to determine the appropriateness of the work hardening and other therapy. A February 17, 2003 staffing note mentioned that Claimant's pain medication was not helping much.

21. A chiropractic peer review on February 19, 2003, concluded that Claimant had experienced a lumbar sprain, that ongoing complaints of pain were not supported by objective testing and examination, and that additional supervised treatment was not warranted.

22. On March 3, 2003, Francisco J. Batlle, M.D., a neurosurgeon, examined Claimant. Lumbar range of motion was full and the neurological results were normal.

23. Dr. Batlle's review of the June 19, 2002 lumbar spine MRI revealed no evidence of (1) a herniated disc; (2) a central canal stenosis; or (3) a bilateral foraminal stenosis. Dr. Batlle noted a small disc protrusion at L5-S1, without significant central or bilateral stenosis.

24. Dr. Batlle diagnosed lumbar disc displacement, lumbago and lumbar myofascial injury.

25. Dr. Batlle concluded Claimant was not a surgical candidate but did suggest that physical therapy might provide symptomatic relief.

26. Dr. Batlle suggested epidural steroid injections if Claimant's symptomology did not abate.

27. Although work hardening began on February 2, 2003, on March 3, 2003, Crawford Sloan, M.D., and Lewis Cone, D.C., authored a letter requesting preauthorization for work hardening.

28. An FCE performed on March 6, 2003, revealed Claimant's pain as 4/10 and recommended that Claimant complete the last two weeks of the six-week work hardening program.

29. Daniel Leong, D.O., examined Claimant on March 17, 2003, at Princeton Pain Management. Range of motion in the cervical thoracic and lumbar spines was normal. Dr. Daniel Leong's diagnostic impressions were (1) disc herniations causing slight spinal stenosis at L3-4, L4-5 and L5-S1; (2) chronic lumbar pain with constant acroparesthesia, weakness and radicular pain to both lower extremities; (3) sexual dysfunction and intermittent urinary incontinence; and (4) sleep disturbances, anxiety and depression.

30. On March 18, 2003, Petitioner noted that Claimant's range of motion was much improved.

31. On March 19, 2003, Dr. Sloan found no significant improvement in condition and noted lumbar range of motion was decreased.

32. On March 26, 2003. Neil J. Atlin, D.O., concluded Claimant had become progressively despondent and depressed.

33. Petitioner's staffing note of March 26, 2003, indicated Claimant was making remarkable progress, exhibited less pain behavior, increased his range of motion and strength and exhibited a better attitude.

34. On March 31, 2003, Claimant underwent another FCE. The recommendation was to return Claimant to work with no restrictions. Petitioner's progress notes for April 1, 7, and 21, 2003, all indicate Claimant's subjective pain was 5/10 and that he was distressed over the unresolved pain.

35. An April 9, 2003 progress note from Princeton Pain Management indicated Claimant had decreased radiculopathy.

36. Epidural steroid injections (ESIs) were administered to Claimant on April 23, 2003, and May 7, 2003.

37. Dr. Sloan saw Claimant on May 12, 2003, and noted a decreased lumbar range of motion.

38. On May 12, 2003, Petitioner noted that Claimant's was distressed over his unresolved pain.

39. Dr. Krejci's treatment plan was for weekly visits until examination warranted a change in frequency. Claimant's anticipated release date was May 30, 2003.

40. On May 12, 2003, Princeton Pain Management noted Claimant had an extreme psychological overlay, high depression and anxiety and suggested two weeks, initially, in a chronic pain management program.

41. On May 19, 2003, Dr. Krejci's progress notes reflect that Claimant's pain was 5/10, that he was essentially unchanged and that Claimant was still distressed over the unresolved pain.

42. On May 21, 2003, Dr. Atlin noted that Claimant's back pain was subsiding but Claimant was depressed. Dr. Atlin indicated Claimant might be a candidate for a chronic pain management program at some time in the future.

43. Dr. Krejci's assessment and treatment of Claimant on May 30, 2003, was unchanged from previous assessments and treatments, except the anticipated release date was postponed until June 30, 2003.

44. A May 30, 2003 Pain Mental Health Evaluation administered by Patsy C. McNatt, a licensed professional counselor, revealed Claimant believed his condition had deteriorated since the date of injury.

45. Ms. McNatt noted numerous inconsistencies in Claimant's self-reporting, testing and observed performance. Claimant's pain was not so severe as to present a significant obstacle for return to work.

46. Claimant was referred to Princeton Pain Management's Outpatient Chronic Pain Management Program.

47. Dr. Krejci's assessment and treatments continued unchanged through June with the exception that the anticipated release date was again delayed one month.

48. On July 15, 2003, Dr. Dorothy Leong performed a second Designated Doctor Examination of Claimant. Claimant's neurological examinations of June 27, 2002, July 25, 2002, November 20, 2002, and March 3, 2003, were all normal. Claimant showed significant indications for symptom magnification.

49. Dr. Dorothy Leong diagnosed Claimant as having low back pain with symptom magnification. She finds Claimant has reached MMI as of July 7, 2003, and assessed a 5% whole person impairment.

50. On July 30, 2003, Claimant underwent a manipulation of the spine, under anesthesia, at the Vista Medical Center Hospital.

51. On August 22, 2003, Dr. Krejci's treatments and assessment of Claimant continued unchanged, except the anticipated release date was delayed until October 30, 2003.

52. On August 29, 2003, Claimant underwent a lumbar discogram to study the L3-4, L4-5 and L5-S1 levels. The radiographic appearance of all three levels was normal. The pain at the L5-S1 level was the most severe and most concordant with the pain Claimant experiences. The post-discogram CT scan revealed no obvious disc protrusion at any level.

53. American Home Assurance Company (Respondent) denied Petitioner reimbursement for work hardening, office visits, treatments and physician conferences from March 25, 2003, through May 19, 2003, as not medically necessary.

54. The Texas Workers' Compensation Commission (Commission), acting through Independent Review Incorporated, an Independent Review Organization (IRO), determined the services provided by Petitioner between March 25, 2003, and May 19, 2003, were not medically necessary for the treatment of Claimant.

55. Petitioner timely requested a hearing before the State Office of Administrative Hearings (SOAH).

56. The hearing convened on February 12, 2004, with State Office of Administrative Hearings (SOAH) ALJ Howard S. Seitzman presiding. Petitioner was represented by Scott Hilliard and Respondent appeared through its counsel, Jane Lipscomb Stone. The hearing concluded and the record closed that day.

57. The amount in dispute is $2302.40.

58. Claimant suffered a lumbar sprain/strain.

59. Claimant had significant symptom magnification.

60. Claimant was not a candidate for work hardening.

61. Even though Petitioner began work hardening on February 2, 2003, it should have ceased work hardening sessions on February 12, 2003.

62. Work hardening was not reasonable or medically necessary for Claimant.

63. Claimant's condition lacked demonstrated improvement.

64. Despite the lack of improvement, Petitioner failed to consider altering or suspending the unsuccessful course of treatment.

65. The office visits, treatments and physician conferences for which Petitioner seeks reimbursement were not reasonable or medically necessary.

III. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Texas Workers' Compensation Act, specifically TEX. LABOR CODE ANN. § 413.031(k), and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMIN. CODE ch. 148.

3. The request for a hearing was timely made pursuant to 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided according to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5. Petitioner has the burden of proof in this matter. 28 TEX. ADMIN. CODE §§ 148.21(h) and 133.308(w).

6. Petitioner failed to prove by a preponderance of the evidence that the services it provided to Claimant from March 25, 2003, through May 19, 2003, were reasonable or medically necessary.

ORDER

THEREFORE IT IS ORDERED that Central Dallas Rehab is not entitled to reimbursement from American Home Assurance Company for charges associated with services it provided to injured worker ___ from March 25, 2003, through May 19, 2003.

SIGNED March 16, 2004.

HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS