DOCKET NO. 453-04-0364.M5
MR NO. M5-03-0846-01

SUHAIL AL-SAHLI, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
VS.	§	**OF**
	§	
METROPOLITAN TRANSIT	§	
AUTHORITY OF HARRIS COUNTY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Suhail al-Sahli, D.C. (Provider), seeks reimbursement of $7,764 from Metropolitan Transit Authority of Harris County (Carrier) for physical therapy services, office visits, and a work hardening program provided to an injured worker between February 27, 2002, and July 26, 2002. Carrier denied payment, primarily on the grounds that the treatment was not medically necessary. That denial was upheld by Independent Review Organization (IRO) acting on behalf of the Texas Workers' Compensation Commission (the Commission). The Medical Review Division (MRD) of the Commission reviewed some additional chiropractic services that had been denied by the Carrier because of inadequate documentation. MRD also found Provider's documentation to be inadequate.[1] In this appeal, Provider did not meet its burden of proving that either the decision of the IRO or the MRD was incorrect. Therefore, the Administrative Law Judge (ALJ) concludes that additional reimbursement is inappropriate.

I. PROCEDURAL HISTORY

ALJ Nancy N. Lynch convened and concluded the hearing in this case on January 20, 2004. Provider appeared and represented himself. Carrier appeared through its attorney, Steven M. Tipton. Notice and jurisdiction were not disputed and will be addressed in the fact findings and legal conclusions set out below.

[1] With the exception of CPT code 97250 on February 11, 2002, for which it recommended reimbursement in the amount of $43.00. This finding was not appealed, so this date of service is no longer in issue.

II. BACKGROUND

A. The Law

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. Specifically, an employee is entitled to health care that cures or relieves the effects naturally resulting from a compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEXAS LABOR CODE (Act), § 408.021(a) (1-3). "Health care" includes all reasonable and necessary medical aid, medical examinations, medical treatment, medical diagnoses, medical evaluations, and medical services. Act, § 401.011(19). Provider has the burden of proof in this case because he appealed the decision of the MRD\IRO. 28 TEX. ADMIN. CODE (TAC) § 148.21(h).

2. Summary of Facts

Claimant, a __-year-old male, was injured on___, while working for Carrier as a bus driver. A car cut him off, and, as he tried to avoid it, he hit a concrete embankment, causing significant damage to the front of the bus. He sustained injuries to his left forehead, left shoulder, and left thigh. He was taken to Hermann Emergency Room, where a cut on his head was closed with stitches. He initially had some whiplash type complaints and had ongoing pain in his shoulder as well as in his thigh.

Claimant originally saw another doctor, and first consulted Provider in January 2002. He received chiropractic treatments and a work hardening program from Provider. The medical necessity of those services, as well as the adequacy of documentation, is in issue in this appeal.

C. The IRO Decision

The IRO concluded that the physical therapy, office visits, and work hardening services provided to Claimant by Provider between April 29, 2002, through July 26, 2002, were not medically necessary. In support of its conclusion, it cited the following:

$ Dr. David Randall's examination on January 15, 2002, indicated Claimant was improving and had nearly full ROM in his left shoulder. Dr. Randall indicated that an active conditioning protocol would be appropriate for about two weeks.

- $ The April 18, 2002, FCE demonstrated Claimant could handle his job description as of that date.
- $ Since he could handle his job requirements as demonstrated by the April FCE, Claimant did not need this type of care after that date.

D. The MRD Decision

The MRD agreed with the Carrier and found that chiropractic services provided from February 11, 2002, through April 5, 2002, were not adequately documented,[2] with the exception of CPT code 97250 (myofascial release) on February 11, 2002. Carrier did not appeal the MRD order requiring reimbursement in the amount of $43.00, so that ruling is not in issue in this appeal.

E. The Evidence

There was no testimony in this case. The appeal was submitted on the basis of exhibits, consisting of approximately 290 pages of records, and the arguments of Provider and Carrier.

1. Medical records

Claimant first went to a company doctor who started him on a course of physical therapy and medications and took him off work for three months. He was diagnosed with sprain/strain injuries to the cervical spine and left shoulder as well as a laceration to the head.

On January 15, 2002, Claimant was seen for an initial orthopedic consultation by David C. Randall, M.D., who diagnosed a Grade II acromioclavicular separation in Claimant's left shoulder. Dr. Randall noted:

- $ Full external and internal rotation, a 5/5 rotator cuff strength, and mild tenderness at the acromioclavicular joint.
- $ No numbness or tingling reported in left upper extremity.
- $ Claimant reported he was improving.
- $ Nearly full range of motion (ROM) on the clinic exam.

Claimant told Dr. Randall he had two more weeks of therapy for shoulder ROM and conditioning.

[2] Provider's table of disputed services as admitted into evidence in this case does not begin until February 27, 2002. For the purposes of this Decision, this discrepancy is not significant.

Dr. Randall suggested a functional capacity evaluation (FCE) in approximately ten days, scheduled another exam in two weeks, and predicted Claimant would be ready to return to work at that time. Dr. Randall noted that Claimant did have some restrictions in his functioning: "Restrictions at this time are no overhead reaching with his left arm and no lifting more than 10 pounds. He is presently not doing any driving."[3]

On January 17, 2002, Claimant changed treating doctors and first consulted Provider [4] He presumably began receiving active and passive chiropractic treatments from Provider shortly after that consultation, although the first date of service in Provider's table of disputed services in this appeal is February 27, 2002.[5] Provider treated Claimant conservatively, with manipulation, hot/cold packs, ultrasound, exercises, and electrical stimulation.

Claimant continued receiving chiropractic or work hardening services from Provider through July 26, 2002, the last date of service on the table of disputed services. There is also evidence in the record that he continued being treated by Provider well beyond that date.

On February 18, 2002, Claimant had an MRI of his left shoulder.[6] The report characterized the MRI as normal, but recorded a number of impressions, including:

- $ Mild to moderate hypertrophy changes at the AC joint compartment. Sizable effusion of the AC joint, consistent with moderate to severe acromion bursitis with joint capsule distention, associated with other indications of moderate to considerable impingement syndrome.
- $ Small fluid-signal . . . noted along the tendon sheaths of the long head of the biceps tendon, suggesting nonspecific tendinitis and/or extended fluid from the glenohumeral joint.
- $ The subscapularis tendon and glenohumeral ligaments are within normal limits.

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[3] Provider Ex. 1 pp. 159-160.

[4] Provider Ex. 1, p. 186. Although pages 186-194 do not have any letterhead or signature, they appear, in context, to be Provider's notes of Claimant's office visits.

[5] Provider Ex. 1, p. 4.

[6] Provider Ex. 1, pp. 195-196.

- $ The supra and infraspinatus tendons are normal. No rotator cuff tear is noted.
- $ The labra are intact.
- $ The coracohumeral ligaments show no tear or capsulitis.
- $ Otherwise, unremarkable MRI of the left shoulder.

On March 13, 2002, Claimant had an EMG that showed a mild C7 radiculopathy on the left and a left mild median nerve lesion.

On March 15, 2002, Claimant was examined by Masroor Ahmed, M.D., at Texas Pain Solutions, on a referral from Provider. The records indicate Dr. Ahmed also saw him on June 28, July 12, August 9, and August 28, 2002. In June, Claimant reported a pain level of 6/10; in July it was around 4/10; on August 9, he reported 3-4/10; on August 23, he reported 4/10. He received medications and trigger point injections during that time. On August 28, 2002, Dr. Ahmed's plan for Claimant included a trial of a TENS unit for thirty days.

On April 18, 2002, Claimant had a FCE to determine whether he was able to return to work. During the FCE, Claimant reported he was independent in activities of daily living, with pain on repetitive left shoulder and neck movement. Massage made it feel better; driving more than 30 minutes made it feel worse. He indicated his pain level was 5 on a scale of 10.[7] At the end of the evaluation, it had increased to 6 of 10.

Notations made during this FCE included:

- $ His left hand grip strength was below normal for his age and sex. Cross validation of the handgrip tests indicated a possible lack of maximal effort.
- $ The range of motion (ROM) testing was reported as a "functional" level of left shoulder and cervical ROM, although flexion, abduction and internal rotation were significantly below normal.

$	Flexion	63% of normal
$	Extension	92% of normal
$	Abduction	42% of normal
$	Adduction	86% of normal

[7] On the scale, pain at the level 5 indicates "Strong pain, which is significantly disabling, i.e. significantly limiting my ability to move and to use the painful area."

$	Internal rotation	50% of normal
$	External rotation	83% of normal

- $ He was able to lift 40 pounds from waist to shoulder, 40 pounds from floor to waist and 40 pounds from floor to shoulder on an occasional and on a frequent basis. He used a poor biomechanical technique during the lifting tests.
- $ He demonstrated the ability to:
  - $ carry 35 pounds over a distance of 30 feet,
  - $ static push an average of 72.8 pounds,
  - $ static pull an average of 99.0 pounds of force.

Claimant filled out a neck disability index, designed to provide information about how his neck pain affected his ability to manage in everyday life. He checked the following:

- $ The pain is very severe at the moment.
- $ I can look after myself normally but it causes extra pain.
- $ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- $ I can read as much as I want to with moderate pain in my neck.
- $ I have slight headaches which come infrequently.
- $ I have a fair degree of difficulty in concentrating when I want to.
- $ I can do most of my usual work, but no more.
- $ I can drive my car as long as I want with moderate pain in my neck.
- $ My sleep is mildly disturbed (1-2 hours sleepless).
- $ I am able to engage in most, but not all of my usual recreational activities because of the pain in my neck.

The index resulted in Claimant's perceived disability percentage rating being assessed at 40% and "moderate."

According to the FCE, Claimant's job tasks included requirements that he be able to lift a maximum of 40 pounds and a minimum of 30 pounds floor to waist, waist to shoulder, floor to shoulder, and overhead.[8] Results of the testing indicated he could lift the required amount for the tasks required although there were no test results reported for overhead lifting. Other abilities compared to job requirements included:

[8] Provider's Exh. 1, Part C, p. 71.

	Reported ability	Required ability
Sitting	three to six hours daily	four to eight hours
Standing	less than three hours a day	one to three hours
Walking	less than three hours a day	one to three hours

Barriers to a successful return to work were listed as shoulder pain and weakness, neck pain, and generalized weakness. Treatment was projected to last six weeks. The "Recommendations" part of the report read: "as per referring doctor." The referring doctor was Provider.

On May 13, 2002, Alain E. Elbaz, M.D., an orthopaedic surgeon, recommended surgery. He thought he detected some signs of a labral tear or some post-traumatic instability. He noted that the passive ROM was painful and that the impingement test was negative. He did not discuss the MRI that found the labral to be intact, as well as indicators of "moderate to considerable impingement syndrome."

On July 17, 2002, Claimant saw orthopaedic surgeon Dr. David G. Vanderweide for a required medical examination (RME). Dr. Vanderweide opined that Claimant could return to work without restriction. On examination, he found Claimant to have a full ROM, a negative impingement sign and a negative supraspinatus sign. He found no crepitation. He thought there was a possible AC separation, but found no evidence of labral pathology. His view was that chiropractic attentions beyond four to six weeks after the accident were unreasonable and unnecessary.[9]

On July 29, 2002, Claimant underwent a second FCE. The examining doctor reported that Claimant had demonstrated the physical abilities necessary for him to return to his previous position as a bus driver. Claimant reported he was independent in handling his activities of daily living and that his pain had markedly decreased. Other notations included:

- His left hand-his dominant hand-was still a little below normal.
- His right hand grip was normal.
- His left shoulder ROM was normal.

[9] Respondent's (Carrier's) Ex. 3.

- He demonstrated the ability to lift 30 pounds from waist to shoulder, 40 pounds from floor to waist, and 30 pounds from floor to shoulder on an occasional basis.
- He demonstrated the ability to:
  - carry 50 pounds over a distance of 30 feet.
  - static push an average of 137.2 pounds
  - static pull 115.4 pounds of force

The FCE report noted that there had been some surveillance during which Claimant had been driving at a rather fast rate of speed, making swift lane changes. Motions were described as swift, with no outward signs of discomfort or limitation.

On October 31, 2002, plain films of the cervical spine were basically normal.[10] The plain film examination did not reveal any fracture, dislocation, destructive bone or joint disease. The cervical lordosis was well maintained. The disc spacing was within normal limits. The soft tissues did not show any abnormal masses or calcifications.

In November 2002, Provider again noted Claimant had some pain in his left shoulder and minimal ROM. He provided manipulation of Claimant's neck.

On February 13, 2003, Charles F. Xeller, M.D., performed an independent medical evaluation of Claimant to determine whether he had reached maximum medical improvement (MMI). Dr. Xeller concluded that Claimant apparently had a first degree separation of the left AC joint. He observed a slight crepitation with motion of Claimant's shoulder and some decrease in active ROM. He concluded that Claimant's MRI showed some tendonitis, but no frank tears.

Dr. Xeller also noted that Claimant had been advised to have shoulder surgery. However, he wanted to avoid it because he felt he was too young. Claimant continued to complain of ongoing pain in his left shoulder, especially with overhead-type movements. Claimant was taking Naprosyn, Ultracet, and Skelaxin. After he changed treating doctors to Provider, Claimant had on-going chiropractic treatment three times per week. Dr. Xeller also noted that Claimant had returned to

[10] Provider Ex. 1, p. 171.

work and was working without restrictions, although he stated he had some pain with overhead lifting.[11]

Dr. Xeller saw no need for ongoing treatment. The July FCE reported that Claimant could return to full work. Dr. Xeller thought he might have some pain with overhead maneuvers, but he did not believe Claimant had any restrictions. He concluded Claimant had reached MMI. Dr. Xeller assigned a total upper extremity impairment of 10 per cent for lack of ROM and slight crepitation in his left shoulder. This converted to a whole person impairment of 6 per cent.

2. The Disputed Services

Between February 27, 2002, and June 17, 2002, Claimant received a number of physical medicine modalities and treatments, and office visits from Provider. The services provided and the amounts sought for reimbursement for each are as follows:

CPT code 97110	therapeutic exercises, one on one	$1,645
CPT code 97250	myofascial release	602
CPT code 99213	manipulation	528
CPT code 97035	ultrasound, constant attendance	242
CPT code 97014	electrical stimulation (unattended)	100
CPT code 97265	joint mobilization	43
CPT code 97124	massage	35
	Total:	$3,220

Records submitted to support this claim included daily notes, dated from March 27, 2002, and through June 17, 2002.[12] There is no documentation for the following dates that are listed in the table of disputed services: February 27, March 1, April 5, and May 13, 2002. There are SOAP notes for April 29, May 6, May 8, 10, 15, 17, 20, June 10, 12, 14, and 17, 2002.[13]

Claimant also went through a work hardening program with Provider between July 3, 2002, and July 26, 2002, for a total of four weeks. Provider seeks reimbursement for the last two weeks of

[11] Provider's Exh. 1, p. 182.

[12] Provider Ex. 1, pp. 4-8.

[13] Provider Ex. 1, pp. 49-62.

that program in this appeal, in the amount of $4,480.[14]

Work hardening records in the exhibits included:

- $ Weekly team conference reports for the 1st, 3rd, and 4th weeks.
- $ An undated note from a licensed professional counselor describing Claimant's participation in a biofeedback session.
- $ Approximately 48 pages of exercise sheets, work simulation sheets, and pain locator and intensity indicator sheets.

Carrier's exhibits included a report from Brian Randall, D.C., prepared at Carrier's request when Provider sought preauthorization for the work hardening program.[15] The peer review doctor reviewed Claimant's records, including the FCE performed on April 18, 2002, a preauthorization request from Provider, Dr. Ahmed's evaluation report of March 15, 2002, and the MRI performed on February 18, 2002. He then opined that a work hardening program was not medically necessary because Claimant was functioning at a medium physical demand level, which was consistent with his job requirements. He also noted that there are usually behavioral and attitudinal issues to be addressed in a work hardening program, but Claimant had reported no problems in either of those areas. Further, Dr. Randall noted, Claimant had not provided maximal effort according to the hand grip test and cross-validation of the hand grip test. Therefore, Dr. Randall did not believe a work hardening program would produce any increase in function or decrease in pain for this Claimant.

III. PARTIES' ARGUMENTS

A. Provider

1. Claimant's ability to return to or retain employment was enhanced by its treatments and, therefore, Provider is entitled to full reimbursement. Act, § 408.021.

Provider argued that, without its treatments, including the work hardening program, Claimant would not have been able to meet the requirements of his job as a bus driver. He offered a 1992 job description of a Metro bus driver to prove that Claimant had to be able to push or pull weights of

[14] There is a difference of $64 between Claimant's number and the ALJ's number when adding up the requested reimbursement amounts. This is not significant, however, given the final determination of the ALJ.

[15] Preauthorization is not an issue in this appeal. Carrier's Ex. 2.

150-300 pounds, for example, a large person in a wheelchair, to fulfill his job requirements. He could not do that at the time of the April FCE, but, Provider argued, he could do it after the work hardening program. Therefore, he obviously improved and the treatment he received in the work hardening program enabled him to gain the functional capacity he needed to return to his job. In support of his argument, he cited the designated doctor's examination. He also pointed to the increase in Claimant's left shoulder ROM, the primary goal of treatment.

2. Carrier failed to comply with TWCC rules regarding EOBs and peer reports and, therefore, it cannot challenge his charges in this appeal.

Provider argued that Carrier did not provide sufficiently specific reasons why it denied payment, thereby violating the Act, § 408.27(d), and Commission rules, 28 TAC § 133.304(c), and § 133.300. He also complained that the peer review was not attached to the EOB, as required by Commission rule, 28 TAC §§ 133.305(a) (3) and (4).

2. Carrier.

1. Physical therapy.

Carrier argued the physical therapy was not medically necessary because Claimant was capable of returning to work as a bus driver at the time of the FCE on April 18, 2004. Furthermore, the physical therapy charges were duplicative. Because of the similar nature of the treatment, Carrier argued that the following CPT codes should not be billed on the same day: 97250Bmyofascial release, 97265Bjoint mobilization, 97012Bmechanical traction, and 99213-MP. Carrier also argued there was not sufficient documentation of the need for one-on-one therapy as billed by Claimant under CPT Code 97110.

2. Sufficiency of the EOBs.

Carrier argued its EOBs were sufficient: they stated the explanation (the denial code) and the ground (the reason for reduction/denial). It maintained it did not have to cite all the evidence that supported each explanation and ground. As to providing the peer report with the EOB, Carrier maintained that it was sufficient to provide it separately. As a practical matter, Carrier argued, the EOB and the peer report are generated in separate places, and it would be impractical to require the

peer report to be stapled to the appropriate EOB. All that was required was that the Provider receive a copy of the peer report-and Provider did receive a copy of the peer report in this case.

Finally, Carrier argued that nothing relieved Claimant of complying with the rules and regulations of the Commission, even if the Carrier failed to strictly comply with all the rules. The medical services provided to Claimant by Provider had to be medically necessary under the law. The Commission has an independent duty and responsibility to ensure that all health care providers and insurance companies comply with its policies and guidelines.

3. Work hardening program.

Carrier argued that Claimant was not an appropriate candidate for a work hardening program because such programs are required to take an interdisciplinary approach. They are intended to address physical, vocational, and behavioral issues. In this case, however, there is no indication Claimant needed services in either the vocational or behavioral areas.

Carrier also argued that the program provided to Claimant was not a real work hardening program. It was a generalized, overall conditioning program. Claimant did cardiovascular training, ROM, building tasks, shoveling, and various weight exercises and box lifting, but there is no indication why these exercises were necessary or how they enabled this employee to return to his job as a bus driver.

IV. ANALYSIS

A. Physical medicine services

The ALJ concludes that Provider did not prove that the physical medicine services it provided Claimant were reasonable and medically necessary. They may have made Claimant feel better, but that is not enough. Provider is required to document the reasonableness and necessity of the services it provides to a workers' compensation claimant. It failed to do that adequately.

The Physical Medicine portion of the Medicine Ground Rules establish requirements for reimbursement for treatment. The patient's condition must have the potential for restoration of

function. It is not clear that this patient did have the potential for restoration of function, given how little progress he made compared to the amount of treatment he was given and considering that at least two doctors recommended surgery. The treatment must also be specific to the injury, must provide for the potential improvement of the patient's condition, and the treatment plan must be in writing and on file with the health care provider, with copies sent to the carrier.

A treatment plan shall contain the following:

a. type of intervention/treatment modality
b. frequency of treatment
c. expected duration of treatment
d. expected clinical response to treatment, and
e. specification of a re-evaluation time frame.[16]

The record in this case does not appear to contain an actual treatment plan. Provider first examined Claimant on January 17, 2002. In a report dated January 28, 2002, he described Claimant's symptoms as "constant neck pain mainly on the left side, upper back and left shoulder pain with radiation of pain to his upper left extremity." The only hint of a treatment plan in that report is the following:

> I plan to order an MRI of the cervical spine to rule out disk herniation and left should to rule out rotator cuff tear. The recommended treatment at this time is proper physical therapy modalities and rehabilitation. The frequency will be based on the patient's needs and prognosis. This recommendation is made with consideration of the acuity of the patient condition, and my exam findings.[17]

The prognosis included in that report was: "Guarded at this time."[18]

The report dated February 27, 2002, included the exact same language in a section titled

[16] *Medicine Ground Rules, Medical Fee Guideline,* adopted 1996, p. 31.

[17] Provider Ex. 1, p. 186.

[18] Provider Ex. 1, p. 188.

"Treatment Plan." It also included short-term goals: "to increase the patient ROM of the cervical spine and left shoulder, reduce the patient's pain level by 2-3 levels, and bring the patient level to functional capacity evaluation." He also planned to refer him for an orthopaedic evaluation of the left shoulder to rule out surgery. Long-term goals were: "restore full ROM, strength, and help the patient return to full gainful employment." The prognosis was: "Guarded at this time."[19]

The next report in the record is dated May 10, 2002. This report indicates his treatment plan then was to refer Claimant for an FCE evaluation. The recommended treatment is to be determined based on the FCE outcome. The frequency would be based on the patient's needs and prognosis.

The short-term and long-term goals were identical to those in the report written three months earlier. Prognosis was recorded as "good."[20]

The ALJ found nothing else in the record that could purport to be a treatment plan. Provider did not cite anything in the record that it claimed was a treatment plan. Having a treatment plan is an essential part of documenting that physical medicine treatment is reasonable and medically necessary.

In addition, the daily SOAP notes do not adequately document the reasonableness and medical necessity of the provided services. Daily SOAP notes are missing from the following dates that appear on the table of disputed services: February 27, March 1, April 5, and May 13, 2002. There are SOAP notes for April 29, May 6, May 8, 10, 15, 17, 20, June 10, 12, 14, and 17, 2002. However, those SOAP notes are repetitive and fail to document the medical necessity of the services provided. For example, the note for May 6 states:

> The patient entered the office complaining of throbbing shoulder pain that feels better for a few hours after therapy. The patient described the pain as moderate and increases upon daily activities. The examination revealed moderate to mild Limited

[19] Provider Ex. 1, pp. 189-190.

[20] Provider Ex. 1, p. 192.

range of motion of the shoulder and c/ spine, slight spasm and tenderness to palpation of the shoulder muscle with MM weakness.

Treatment today consisted of ultrasound, an adjustment and electric stimulation and Rehabilitative exercise program (the program was performed to help increase endurance and strength. This was performed on a one-to-one basis with the patient) included the following exercises: stretching and theratubing exercises for 1 hour. The patient should return three times a week or as needed. Pt. was referred for an FCE and possible work hardening. *[sic]*[21]

These records, when considered along with the FCE of April 18, 2002, are not sufficient to establish that the health care services rendered were reasonably required by the injury as and when needed. There is very little indication that the patient was improving in response to the physical medicine treatment he was receiving.

B. The work hardening program

A work hardening program is described as:

a highly structured, goal-oriented, individualized treatment program designed to maximize the ability of the persons served to return to work. They are interdisciplinary in nature with a capability of addressing the functional, physical, behavioral, and vocational needs of the injured worker. . . . Work hardening programs use real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks.[22]

Claimant was clearly not an appropriate candidate for a work hardening program because he did not need an interdisciplinary program. This is demonstrated clearly by the two weekly conference reports in the record. One of them notes the patient "does not want voc [i.e. vocational]

[21] Provider Ex. 1, p. 52.

[22] *Medical Fee Guideline*, 1996, p. 37.

but available if he changes his mind."[23] In addition, the notations on the behavioral axis for both weeks indicated he was not stressed. Still, the Provider's note says, "encourage patient to recognize stress rather than deny it."[24]

Neither was there any indication the work hardening program Claimant was designed to meet Claimant's particular needs and get him back to work. The records indicate it was a very generalized fitness improvement program. Provider argued that he improved during this time and that the FCE after the program indicated he could return to work. However, the April FCE also indicated he was meeting his job requirements although he still had some pain. Perhaps he did need some kind of health care. However, to show that the health care provided is reasonable, there should be some evidence that it is appropriately targeted to the individual's particular needs. Health care providers may not provide the most elaborate health care program possible when a less intense, and less expensive, method could produce the same results. In addition, the work hardening program that Claimant received from Provider was not sufficiently documented to prove its necessity.

Finally, the EOBs submitted by the Carrier were sufficient to inform Provider of the reason it had denied reimbursement for the services involved in this appeal. It was also apparent that Provider had received the peer review report.

Having considered the evidence and the arguments, the ALJ concludes that Provider did not prove the health care services it provided were reasonable and medically necessary for this Claimant. Neither did Provider prove those denied on the basis of documentation had been adequately documented.

V. FINDINGS OF FACT

1. On____, Claimant, a __-year-old bus driver, suffered a compensable injury under the Texas Workers' Compensation Act (Act). While driving a bus, he was cut off in traffic and served to avoid the car, colliding with a concrete embankment. He sustained injuries to his left forehead, left shoulder, and left thigh.

[23] Provider's Exh. 1, p. 73.

[24] Provider's Exh. 1, pp. 74, 76.

2. At the time of Claimant's injury, his employer, Metropolitan Transit Authority Houston (Carrier), self-insured for workers' compensation claims.

3. Suhail al-Sahli, D.C., (Provider) seeks approximately $7,764 for physical therapy, office visits, and a work hardening program provided between February 27, 2002, and July 26, 2002.

4. Carrier denied reimbursement for these services.

5. Provider timely requested dispute resolution.

6. An Independent Review Organization (IRO) reviewed the chiropractic services, office visits, and the work hardening program provided from April 19, 2002, to July 26, 2002, that were denied based on medical necessity.

7. The IRO agreed with Carrier that the services and office visits provided were not medically necessary.

8. The Texas Workers' Compensation Commission Medical Review Division (MRD) reviewed services not reviewed by the IRO, including dates of services beginning February 11, 2002, through April 5, 2002. These services were denied by the Carrier based on lack of documentation.

9. The MRD found documentation was adequate for CPT Code 97250 on February 11, 2002, and ordered reimbursement in the amount of $43.00 for that date and service. This is not in dispute in this appeal because Carrier did not appeal the order of MRD.

10. Provider did timely request a hearing at the State Office of Administrative Hearings (SOAH).

11. Notice of the hearing was sent to the parties on October 3, 2003. The notice informed the parties of the date, time, and location of the hearing, a statement of the matters to be considered, the legal authority under which the hearing would be held, and the statutory provisions applicable to the matters to be considered.

12. The SOAH hearing took place on January 20, 2004, before Administrative Law Judge (ALJ) Nancy N. Lynch. Provider appeared and represented himself. Carrier appeared through its attorney, Steven M. Tipton. The record closed on the same date.

13. Provider failed to complete a treatment plan for the physical medicine services and to maintain other documentation as required by the 1996 *Medical Fee Guideline (Guideline)* Medicine Ground Rule I, adopted at 28 TEX. ADMIN. CODE (TAC) § 134.201.

14. Provider's documentation did not explain why particular modalities were necessary, did not describe the exercises being used, what they were meant to accomplish, and did not set out the expected time frame of Claimant's treatment.

15. Provider did not offer any evidence to show it was medically necessary to provide myofascial release, joint mobilization, mechanical traction, and manipulation on the same date.

16. Provider's documentation did not explain why one-on-one supervision was necessary for the exercises described as a rehabilitative exercise program to increase endurance and strength.

17. Carrier denied Provider's claim for reimbursement for physical medicine services and office visits because they were not sufficiently documented and\or they were not medically necessary.

18. The program given Claimant from July 15, 2002, through July 26, 2002, did not meet the work hardening requirements set out in the *Guideline*, Medicine Ground Rule II.E., adopted at 28 TEX. ADMIN. CODE § 134.201, because:

    1. It was not a highly structured, goal-oriented, individualized treatment program designed to maximize Claimant's ability to return to work.
    2. It did not consist of real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks.
    3. There was no indication that an initial evaluation of Claimant's mental health and readiness for the program was performed.
    4. There was no indication that an individualized plan of treatment was created for Claimant.
    5. There was no meaningful documentation of Claimant's daily treatment and response to treatment.

19. The program provided to Claimant was a generalized conditioning program.

20. Claimant was not an appropriate candidate for a work hardening program because he did not have behavioral or vocational issues that needed to be addressed in a multi-disciplinary program.

21. Carrier denied Provider's claim for reimbursement for the work hardening program because it was not medically necessary.

22. The hearing at the State Office of Administrative Hearings was held on January 20, 2004.

VI. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to the Act § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

3. Carrier provided adequate notice before the dispute went to medical dispute resolution of its position that the services it denied were not medically necessary or adequately documented.

4. Provider had the burden of proof in this matter. 28 TEX. ADMIN. CODE §148.21(h).

5. Provider did not prove that the disputed services were reasonable and medically necessary health care for Claimant. Act § 408.021.

6. Based on the foregoing, Petitioner's claim for further reimbursement from the Carrier for the disputed expenses should be denied.

ORDER

IT IS, THEREFORE, ORDERED that Provider's claim for reimbursement from the Metropolitan Transit Authority of Harris County for the physical therapy services and work hardening program provided to the Claimant from February 11, 2002, through July 26, 2002, is hereby denied.

Signed March 25, 2004.

NANCY N. LYNCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS