SOAH DOCKET NO. 453-05-3149.M5
MRD NO. M5-04-1688-01

GALVESTON COUNTY,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
SUHAIL AL-SAHLI, D.C.,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Galveston County (Carrier) denied payment for all services[1] provided by Suhail al-Sahli, D.C., to an injured worker between March 7 and November 5, 2003, on the grounds that the treatment was not medically necessary. An Independent Review Organization (IRO), acting on behalf of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission, (the Commission), determined that the disputed services were medically necessary and ordered Carrier to reimburse Provider for them. Carrier appealed. This decision and order finds that the services were not medically necessary for Claimant and orders no reimbursement to Provider.

I. PROCEDURAL HISTORY

Administrative Law Judge (ALJ) Charles Homer III convened the hearing in this case on May 17, 2005. Provider appeared and represented himself. Carrier appeared through its attorney, Brandi Prejean. Notice and jurisdiction were not disputed and will be addressed in the fact findings and legal conclusions below. The hearing concluded May 17; however, the record was held open for receipt of a complete table of disputed services as determined by the parties. The record was closed May 19, 2005, when the table and notes from Dr. Ahmed concerning epidural steroid injections were received at SOAH, identified as ALJ Exhibit 1, and admitted into evidence.

[1] The invoices for the disputed services plus one other date not considered here total $4,444.66.

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). Carrier has the burden of proof in this case because it appealed the decision of the MRD\IRO. 28 TEX. ADMIN. CODE (TAC) §148.21(h).

2. Summary of Facts

Laura Whipple, D.C., testified for Carrier, who also offered 380 pages of Claimant's treatment and insurance records into evidence. Dr. Al-Sahli testified for himself and offered 150 pages of records into evidence.

Claimant, a 52-year-old male, was injured on ___, while working for Carrier as a juvenile detention officer. The vehicle he was driving rear-ended another vehicle sufficiently hard to cause the air bag to deploy. Claimant felt movement and strain in his back, stomach, and thorax. Soon he was feeling pain in those areas.

Claimant originally saw Scott Stanislaw, M.D., on April 25, 2002, and continued to see him approximately monthly thereafter until a final appointment on September 12, 2002. On the first visit, Dr. Stanislaw found that Claimant had suffered a lumbar spinal strain with mild radiculopathy;[2] at the September 12 visit Dr. Stanislaw discharged Claimant to complete physical therapy and to

[2] Carrier Ex. 1, p. 370.

return if he needed an impairment rating, although he stated that because there were no "hard" findings, he would probably not be able to issue such a rating to Claimant.[3]

Claimant then consulted Provider for the first time in October 2002. He began receiving chiropractic treatments, including exercise therapy. These services continued intermittently through November 5, 2003,[4] the last date of service at issue here. In addition, Claimant has had epidural steroid injections for pain and an MRI (which revealed no significant disc injury or degeneration) and a CT scan of his abdomen, and at least two functional capacity evaluations, one of which is discussed in the Analysis section below.

C. The IRO Decision

The IRO concluded that the physical therapy, office visits, and other services provided to Claimant by Provider between March 7, 2003, through November 5, 2003, were medically necessary. In support of its conclusion, the IRO reviewer cited no other medical review or evaluation of Claimant, but recapitulated the history of Claimant's treatment for his compensable injury and stated the following:

> The diagnoses for this patient have included lumbar sacral spine and sprain [*sic*], contusion of the abdomen, and contusion of the hip. . . . The . . . chiropractor reviewer further noted that treatment for this patient's condition has included physical therapy, chiropractic treatment, pain management, injection, nerve blocks and epidural steroid injections. The . . . chiropractor reviewer explained that the treatment in question from 3/7/03 through 11/5/03 was appropriate and medically necessary to treat this patient's condition. Therefore the . . . chiropractor consultant concluded that the self care mngt trang, neuro reed, ultrasound, chiro man spinal, myofas rel, gait train, ther exer, ov, mech tract, spec srv or report, mas ther, chiro man treat, and CPT code 99371 from 3/7/03 through 11/5/03 was appropriate and medically necessary to treat this patient's condition.

[3] *Id*., p. 375.

[4] ALJ Ex. 1. The records show another date of service, November 7, 2003, that is not at issue here. The MRD did not decide the medical necessity of services rendered on that date; therefore, that date of service is not before the ALJ. During the eight-month period of disputed services, the Provider saw Claimant 20 times.

III. ANALYSIS

The ALJ concludes that Carrier proved by a preponderance of the evidence that the physical medicine services Provider furnished to Claimant were not medically necessary. At the beginning date of those services, there was no indication that Claimant required more chiropractic care (or any other kind of care) for his compensable injury, a lumbar strain incurred almost a full year before the disputed services commenced on March 7, 2003.

Records submitted by both parties indicate that Claimant was first seen after his accident at Mainland Hospital, where he was treated and released. He was seen one week later by Scott. R. Stanislaw, M.D., an orthopedist, who diagnosed him with lumbar strain and noted Claimant's complaint of mild pain radiating into the right leg as far down as the knee.[5] Dr. Stanislaw also noted that Claimant suffered from chronic testicular pain that was being managed with pain medication and Duragesic patches by a Dr. Alvarez. Dr. Stanislaw planned conservative treatment with rest, ice, and activity modification, and he requested an MRI because of the radiating pain.[6] On May 23, 2002, Claimant returned and Dr. Stanislaw told him that his MRI was normal with no evidence of a disc herniation. Dr. Stanislaw instructed Claimant to continue physical therapy until his next scheduled visit with and stated that return to work would be considered at the next visit.

At the June visit with Dr. Stanislaw, Claimant reported that his low back pain was "resolved." He reported continued pain in his right side and upper flank and abdomen, which had been present since the accident and worsened with physical therapy. Claimant was concerned that this pain might be related to his liver (previously, he had hepatitis and a gall bladder surgery). The doctor's examination revealed Claimant to have a "good range of motion, non-tender lumbo-sacral spine, and

[5] Carrier Ex., p. 370.

[6] *Id.*

normal sensations and a normal gait." Dr. Stanislaw planned for "completion of physical therapy" and for referral to Claimant's gastroenterologist for possible liver injury.[7]

Dr. Stanislaw appears to have seen Claimant for the last time on September 12, 2002, when he wrote that Claimant had been worked up by CT scan for gastro-intestinal problems; the CT scan ruled out liver damage. Again Dr. Stanislaw observed Claimant to have a normal gait, no muscle spasm, intact sensation, and nontender lower lumbar spine.[8] The plan was to refer Claimant to a spine specialist to rule out some non-apparent spinal "pathology with regard to the MRI scan," and for "completed physical therapy." Dr. Stanislaw wrote that he would see Claimant again if Claimant sought an impairment rating, but that in the absence of "hard clinical findings," it was "not likely that I will be able to provide any significant impairment rating for this complaint."

Despite this apparent conclusion of treatment for all conditions that were even possibly related to his compensable injury, Claimant saw Provider for the first time on October 14, 2002. Provider began conservative treatment of Claimant and, before October 18, referred Claimant to Masroor Ahmed, M.D., for pain management.[9] Dr. Ahmed began pain management and referred Claimant to Provider for the associated chiropractic care: "physical therapy and Chiromanipulation."[10] Claimant continued receiving chiropractic services from Provider through November 5, 2003, the last date of service on the table of disputed services.[11]

At the hearing, Provider admitted that his treatment of Claimant lasted "longer than usual," and pointed to Carrier's denials of preauthorizations for services as part of the reason. Provider also

[7] Carrier Ex. 1, p. 371.

[8] Carrier Ex. 1, p. 375.

[9] Provider Ex.1, p. 51.

[10] Provider Ex. 1, p. 53.

[11] ALJ Ex. 1 contains billing information for services rendered on November 7, 2003. However, the MRD apparently did not have these services before it; because there is no MRD decision concerning the November 7 services, the ALJ cannot issue a decision concerning them.

supported his treatment of Claimant by citing Dr. Ahmed's directions for "one day"[12] of physical therapy after each set of epidural steroid injections. Finally, Provider argued that its treatments for Claimant were part of the two "designated doctors'" recommendations for him, and thus were medically necessary.

Claimant's back injury had been evaluated via MRI and his symptoms, never severe, had resolved nine months before March 2003, according to Dr. Stanislaw. The records show that Claimant was already under pain management for his testicular pain before the wreck that injured him. The record further shows that both Claimant and Dr. Stanislaw considered that Claimant's flank and abdominal tenderness might be related to Claimant's hepatitis, but not to his accidental injury.

Provider refers to his documentation of Claimant's care, and points out what he believes is a significant reduction in Claimant's range of motion in his lumbar spine. But in June 2002, nine months before the first disputed services, Dr. Stanislaw found that Claimant's range of motion was good.

Similarly, Provider cites the November 11, 2002 report to the Commission by Dr. Mayorga as a designated doctor for evaluation of Claimant. Despite noting that x-rays had revealed no intradiscal spacing problems and that an MRI of the lumbar and sacral spine was "essentially within normal limits," Dr. Mayorga wrote that Claimant was awaiting epidural steroid injections and a functional capacity evaluation, and that after those were completed and *if* Claimant was found to be an appropriate candidate, he would benefit from a work conditioning or work hardening program.[13] That evaluation, written four months before the first date of disputed services, does not support medical necessity of supervised exercises, chiropractic manipulations, and the like. Nor would it be persuasive had the evaluation been done on March 6, 2003. The doctor's diagnosis is unsupported by any objective test (e.g., straight leg raising was negative) or diagnostic report. Only Dr. Mayorga's

[12] ALJ Ex. 1

[13] Provider Ex. 1, p. 111.

findings of "some mild to moderate tenderness to palpation, there was painful range of motion and decreased in all directions" offer any support for his diagnosis of "Lumbar Sacral Spine Strain." And that diagnosis, seven months after the compensable injury, predates Provider's first disputed services for Claimant by four months.

The law requires evidence of a compensable injury for which treatment was medically necessary. This Claimant did not see Dr. al-Sahli until almost six months after his April 18, 2002 injury. No treatment guidelines or protocols in evidence at the hearing support the notion that Claimant's injury, which was not detectable via MRI or X-ray, would benefit from Provider's services at or after that date, and certainly not almost eleven months after the injury when the disputed services began.

Claimant, a five foot, six inch male who in October, 2002, weighed between 260 and 270 pounds, certainly benefitted from any exercise that Provider could coax him to perform. But medical necessity in worker's compensation cases does not arise merely from a non-specific benefit to Claimant; the treatment must reasonably be intended to cause an improvement in the compensable injury itself, symptoms related to the injury, or to enable Claimant to overcome the effects of the injury to an extent that he can return to work. In any case, medically necessary treatment must concern itself with effects of the injury, not some other condition.[14] In March 2003, after six months of chiropractic treatment, as Dr. Whipple stated, no further treatment was indicated for Claimant's compensable injury on any theory. If the previous six months had improved his condition steadily, that condition, as slight as it was, would have "resolved," as Dr. Stanislaw put it. If the previous treatment had not improved Claimant, it should have been discontinued long before March 7, 2003, when Carrier disputed Provider's services.

Provider relies on interventions performed by Masroor Ahmed, M.D., who prescribed a day of physical exercise for Claimant after each day of epidural steroid injections. Dr. Ahmed's referral

[14] Act § 408.021(a)(1-3).

fails to prove the medical necessity of Provider's treatment of Claimant, refuted as it is by Carrier's expert witness, a chiropractor, for two reasons. First, Provider relies on a Jacob's ladder of referrals between himself and Dr. Ahmed whereby one referral justifies a referral back and so on, until documentation of treatment, as it did here, reaches the sky. Such a pattern is medically necessary only when there is need for the first and each succeeding treatment, and that need must arise from the injury.

The second reason that Dr. Ahmed's referral notes do not establish medical necessity is that Dr. Ahmed's referrals are unsupported by any reason in his notes or by his testimony (Dr. Ahmed did not testify at the hearing). The ALJ is left to wonder how one day of exercise could benefit a very large man who has just received one or more undoubtedly painful and perhaps even temporarily disabling injections. The ALJ gives some weight to Dr. Ahmed's referrals back to Dr. al-Sahli, but he does not assign them greater weight than the negative clinical findings throughout Claimant's record plus Dr. Whipple's testimony that Claimant's injury and symptoms warranted "no chiropractic care after six weeks." Furthermore, in March 2003 there was no objective indication from Dr. Ahmed's records or any other source that Claimant's injury or symptoms arising from that injury would benefit from additional chiropractic care.

Further, Dr. Whipple testified that she would "absolutely not" have recommended chiropractic care for Claimant's injury in ___. Under Provider's able questioning, Dr. Whipple qualified her answers by saying that she would change her statements if she saw significant improvements, but that she did not see such improvements in Claimant's history. Further, Dr. Whipple testified that rehabilitative medicine is medically necessary for post-injection symptoms only if the injections themselves are medically necessary. She did not believe the injections given Claimant met that test because any improvement was very short-lived: in Dr. Whipple's opinion, medical necessity under the Act does not include treatment that, at relatively high cost, offers Claimant only hours of relief from his pain.

Provider's case is not helped by the IRO reviewer's failure to support his or her conclusion with any other physician's opinions and observations concerning Claimant's treatment. As written, the IRO decision is a mere unsupported conclusion. The ALJ has required Carrier to assume the burden of proof because of the IRO's decision, but that decision accomplishes little more for Provider.

The ALJ concludes that there were no indications that Claimant's compensable injury and the natural effects thereof would, in reasonable medical probability, benefit from the disputed services. Accordingly, Provider should not be reimbursed for the disputed services.

IV. FINDINGS OF FACT

1. On ___, Claimant, a 52-year-old juvenile detention officer, suffered a compensable injury under the Texas Workers' Compensation Act (Act).

2. At the time of Claimant's injury, his employer, Galveston County (Carrier), was self-insured for workers' compensation claims.

3. Suhail al-Sahli, D.C., (Provider) seeks reimbursement of approximately $4,000 for chiropractic services rendered to Claimant between March 7 and November 5, 2003 (disputed services).

4. Carrier denied Provider's claim for reimbursement for the disputed services on the basis of lack of medical necessity.

5. An Independent Review Organization (IRO) found that the services rendered by Provider for Claimant from March 7 to November 5, 2003, were medically necessary for him.

6. On October 14, 2004, the Texas Workers' Compensation Commission's Medical Review Division (MRD) issued its decision and ordered Carrier to reimburse Provider for the disputed services.

7. On November 8, 2004, Carrier requested a hearing.

8. Notice of the hearing was sent to the parties on January 5, 2005. 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.

9. Claimant saw orthopedist Scott Stanislaw, M.D., on April 25, 2002, and continued to see him approximately monthly thereafter until a final appointment on September 12, 2002.

10. On April 25, 2002, Dr. Stanislaw found that Claimant had suffered a lumbar spinal strain with mild radiculopathy.

11. On April 25, 2002, Dr. Stanislaw planned conservative treatment with rest, ice, and activity modification, and requested an MRI because of the radiating pain.

12. Before his compensable injury, Claimant suffered from chronic testicular pain that was being managed with pain medication and Duragesic patches by a Dr. Alvarez.

13. On May 23, 2002, Claimant's MRI of his lumbo-sacral spine was normal with no evidence of a disc herniation.

14. On May 23, 2002, Dr. Stanislaw instructed Claimant to continue physical therapy until his next scheduled visit and stated that return to work would be considered at the next visit.

15. At his June 2002 visit with Dr. Stanislaw, Claimant's low back pain was resolved.

16. Claimant reported continued pain in his right side and upper flank and abdomen, which had been present since the accident and worsened with physical therapy.

17. In June 2002 Claimant had a good range of motion, non-tender lumbo-sacral spine, and normal sensations and a normal gait. Dr. Stanislaw planned for "completion of physical therapy" and for referral to Claimant's gastroenterologist for possible liver injury.

18. A CT scan of Claimant's abdomen ruled out liver damage.

19. In September 2002, Claimant had a normal gait, no muscle spasm, intact sensation, and nontender lower lumbar spine.

20. Dr. Stanislaw's treatment plan on September 12, 2002, was to refer Claimant to a spine specialist to rule out some non-apparent spinal "pathology with regard to the MRI scan," and for "completed physical therapy."

21. On September 12, 2002, Dr. Stanislaw discharged Claimant to complete physical therapy.

22. A reasonable chiropractic protocol for spinal strain such as Claimant's compensable injury is conservative chiropractic care for up to six weeks after the injury, at which point the provider should re-evaluate the patient, probably to release him and refer him to any non-chiropractic provider for needed services.

23. Claimant was not an appropriate candidate for chiropractic care and therapy on March 7, 2003, because he had already received more chiropractic care for his April 18, 2002 injury than protocols suggest, with no specific indication of any reason to continue such treatment.

V. 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 Texas Workers' Compensation Act (Act) § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely appealed the IRO decision.

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

4. Carrier had the burden of proof in this matter. 28 TEX. ADMIN. CODE §148.21(h) and 133.308(w); 1 TAC § 155.41.

5. The disputed services were not reasonable and medically necessary health care for Claimant. Act § 408.021.

6. Based on the foregoing Findings of Fact and Conclusions of Law, Provider is not entitled to reimbursement for services rendered to Claimant for the disputed services. Provider's claim for reimbursement from the Carrier for the disputed expenses should be denied.

ORDER

IT IS, THEREFORE, ORDERED that Provider's claim for reimbursement from Galveston County for the services provided to Claimant from March 7 through November 5, 2003, is hereby denied. Carrier owes Claimant no reimbursement for such services.

Signed July 18, 2005.

CHARLES HOMER III
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS