SOAH DOCKET NO. 453-05-4167.M5
TWCC MR. NO. M5-05-0179-01

PATRICK DAVIS, D.C., **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
EMPLOYERS MUTUAL CASUALTY COMPANY, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Patrick Davis, D. C. (Provider), challenged the decision of the Medical Review Division (MRD) of the Texas Workers' Compensation Commission (TWCC or Commission) denying reimbursement to him for a variety of rehabilitation services provided to ___ (Claimant) between October 27, 2003 and January 30, 2004 (treatment period). This is a mixed medical necessity and fee issues case.

On January 14, 2005, the MRD ruled that some services were not medically necessary. It also ruled that Claimant had failed to document in accordance with agency rules the provision of sessions of one-on-one physical therapy, ultrasound treatments, electrical muscle stimulation, application of topical analgesic, and the provision or use of a TENS unit.[1] Employers Mutual Casualty Company (Carrier) had denied payment for all disputed services and related supplies on the basis that the services were unnecessary treatment, not appropriately documented, or billed at levels above the maximum allowable reimbursement (MAR) for the service provided.

The Administrative Law Judge (ALJ) concludes that Provider met his burden of proof to show that rehabilitation services were medically necessary through November 27, 2003, to treat Claimant, but did not meet it to show that therapy after that date was necessary. Provider failed to document the

[1] Transcutaneous and Neuromuscular Electrical Nerve Simulators (TENS) (E0745). On Claimant's last visit to Provider, on January 30, 2004, this item was used or dispensed to Claimant.

level of service provided in regard to one-on-one physical therapy for any date of service. Provider documented that he had provided ultrasound treatments, electrical muscle stimulation, and used or dispensed a TENS unit in accordance with Commission rules, but failed to appropriately document the application of topical analgesic. Provider met his burden of proof to show that he prepared five work status reports in accordance with Commission rules so should be reimbursed for these.

The hearing in this matter convened on April 25, 2005, in Austin, Texas, with ALJ Cassandra Church presiding. The record-closing date was extended to June 1, 2005, to allow the parties to review and submit legal authority and argument. Carrier was represented by Rebecca M. Strandwitz, attorney; Provider represented himself.

Notice was proper and jurisdiction established in this case.

I. DISCUSSION

A. Applicable Standards

All medical care in this case was provided after August 1, 2003, which is the date on which the terms of the 2002 *Medical Fee Guideline* (MFG) went into effect.[2] The 2002 MFG adopts as the treatment guidelines the Center for Medicare and Medicaid Services polices (CMS policies). Although the 2002 MFG modified or augmented some CMS policies, the standards for physical medicine were not among them.[3] Notwithstanding changes incorporated in the 2002 MFG, the medical necessity for treatment is the key determinant for reimbursement.[4]

---

[2] *See Texas Medical Ass'n v. Texas Workers' Compensation Com'n*, 137 S.W.3d 342 (Tex. App.–Austin 2004, rehearing overruled June 24, 2004). This decision affirmed the District Court judgment and denied a permanent injunction to restrain implementation of the 2002 MFG. 28 TEX. ADMIN. CODE § 134.202(2). Further, it did not change the District Court Judge's determination that the effective date of the 2002 MFG would be August 1, 2003. Final Judgment, Cause No. GN 202203, June 1, 2003 (J. Dietz).

[3] *See* discussion in SOAH Dkt. No. 453-04-6623.M5 (March 2005).

[4] TWCC Advisory 2003-11 (July 15, 2003); *see* Provider's Argument and Authorities (May 15, 2005).

However, applying the CMS standards to this case is problematical since neither disputant referenced these standards at any point in the agency proceeding. Carrier's peer reviewer did not reference or apply them in his report prepared in July of 2004.[5] The IRO reviewer did not discuss these guidelines. The only reference in the MRD Decision is in the rationale section regarding one-on-one therapy.[6] There is nothing in the correspondence between the Parties that suggests they distinguished the new standards from those appearing in the 1996 MFG.[7]

In short, the Parties evaluated the treatment in this case under the standards in the 1996 MFG. The ALJ will first consider the disputed items on the same terms as did the Parties, with reference to the 2002 MFG as may be necessary.

A. History of Claim

On ___, Claimant injured his left elbow when he fell from scaffolding. Claimant suffered a comminuted fracture of the radial head and fracture of the coronoid process of a bone in his left elbow.[8] On October 4, 2003, E. Olayinka Ogunro, M.D., extracted bone fragments from Claimant's elbow and fixed the elbow joint by means of two screws.[9] Claimant had no complications from the surgery. Claimant was then referred to his treating doctor, Provider, for therapy to improve his range of motion (ROM).[10] After the treatment period, it was discovered that Claimant had suffered some, apparently transient, damage to his ulnar nerve.[11]

---

[5] *See* Carrier Exh. 1, pp. 27-29 and 65-69.

[6] Carrier Exh. 1, pp. 1-3.

[7] 28 TEX. ADMIN. CODE § 134.201 (Eff. date April 1, 1996).

[8] A comminuted fracture is one in which the bone is splintered or crushed; a process is a projecting portion of a bone.

[9] Carrier Exh. 1, pp. 4 and 5, 65-73.

[10] Carrier Exh. 1, p. 67.

[11] On February 26, 2004, a needle EMG of Claimant's left arm showed an ulnar motor mononeuropathy in

Provider began post-operative treatment of Claimant on October 27, 2003.[12] During the three-month treatment period, Provider conducted 46 treatment sessions. Sessions included the following treatments in various combinations: extremity manipulation (98943),[13] myofascial release and manual traction (97140), neuromuscular reeducation (97112), one-on-one therapeutic procedures (97110), ultrasound (97035), electrical muscle stimulation (97032), kinetic procedures (97530), and the application of a topical analgesic (99070).

In addition to the treatments, Claimant billed for seven work status reports (99080-73). Carrier denied payment for those reports on the basis they had not been properly documented; one was apparently reimbursed.[14]

There is conflicting evidence over the date on which Claimant was determined to be ready to return to work. Carrier contended that the Dr. Onguro, in consultation with Provider, released Claimant to full duty without restriction on December 3, 2003. However, Provider–Claimant's treating doctor–released Claimant to light duty, *i.e.*, with some lifting restrictions, through January 31, 2004, with return to full duty on January 31, 2004.[15]

Carrier denied reimbursement for *most* services that Provider administered during the treatment period; however, Carrier did reimburse Provider for some manipulation sessions (98943) and related items of durable medical equipment (E1399) in all three months of the treatment period.[16]

Claimant's left elbow. R. Frank Morrison, M. D., stated Claimant showed an active an ongoing reinnervation and gave a favorable prognosis for continued motor return. Provider Exh. 1, pp. 9-12.

[12] Provider Exh. 1, p. 59.

[13] The five-digit numbers are Current Procedural Terminology (CPT) code numbers as they appear in the 1996 MFG.

[14] Carrier Exh. 1, p. 10.

[15] Provider Exh. 1, pp. 25 and 34.

[16] Carrier Exh. 1, pp. 8-24. On the explanation of benefits (EOBs) included in the record, these items showed no denial codes, so the ALJ is assuming those items were approved and paid.

Carrier denied reimbursement for all other services on the grounds there were insufficiently documented (Code N), were not medically necessary (Code U), or were above the MAR (Code F).

In July 2004, Carrier submitted Provider's claims to a peer review. On July 21, 2004, Robert B. Honigsfeld, D.C., concluded that none of the services for which Carrier had denied reimbursement were medically necessary.[17] Dr. Honigsfeld also concluded that Provider had not documented the provision of one-on-one therapy (97110) nor documented that this type of therapy would have been warranted by Claimant's injury.

The MRD upheld the Carrier's denial of reimbursement on all the items. Its denial was based on lack of documentation for the one-on-one physical therapy, ultrasound, manual electrical stimulation, and the TENS unit.[18] The MRD Decision also incorporated the recommendation against reimbursement made by the Independent Review Organization (IRO) for all items denied on the basis of lack of medical necessity (Code U). However, the IRO reviewer also issued an opinion on the *medical necessity* of items that the Carrier had originally denied on other grounds, *i.e.*, passive modalities such as ultrasound, application of analgesic balm,[19] manual electrical stimulation, as well as also the one-on-one physical therapy. The IRO reviewer's conclusion on these treatments must be viewed as commentary since reimbursement for these services was denied on fee grounds.[20] In a long line of SOAH decisions, Carriers have been limited at the contested case hearing to proceeding on grounds raised in the denials incorporated in their EOBs.

The IRO reviewer stated that some level of therapy above just home exercise would have been necessary to treat Claimant. However, the reviewer did not give an opinion as to what the appropriate

[17] Carrier Exh. 1, pp. 65-69.

[18] Carrier Exh. 1, pp. 1-3, and Exh. 2.

[19] While the CPT code for this item is "supplies," the Provider's notes indicate he used this code for application of analgesic balm. Provider Exh. 1, p. 249.

[20] TEX. LAB. CODE ANN. § 413.031.

level of therapy would have been.[21] The reviewer's concern about the particular therapy provided appears to have been based in large part on what he or she considered inadequate *documentation* of the treatments.

B. Medical Evidence

Provider stated that the number of sessions and types of therapy that he administered succeeded in returning Claimant to the work force without performance restrictions. He stated that personnel in his office administered Claimant's therapeutic exercises on a one-on-one basis in order to make sure that Claimant did not re-injure himself. He stated that the passive treatment, including gentle manipulation, helped improve Claimant's arm functioning and that application of analgesic balm reduced Claimant's pain and discomfort.[22]

Dr. Ogunro had prescribed post-operative therapy but left decisions on the duration and activities to Provider. There is no indication that Provider reported the progress of his therapy to Dr. Ogunro or that Dr. Ogunro oversaw the course of therapy in any way.

In regards to the thoroughness of his records, Provider argued that his course of treatment had been properly documented in accordance with chiropractic practice guidelines used in Texas.[23]

Provider's summary of the measurement of Claimant's left arm improvement includes results of motor evaluation tests on a graded scale referencing movement against 'slight' to 'normal' resistance, hand strength as measured by a dynamometer, and elbow ROM.[24] The values for resistance for motor skills are not quantified. Provider stated that the mean value for a person of

[21] Carrier Exh. 2.

[22] Provider Exh. 1, p. 275.

[23] Provider Exh. 1, p. 8. Provider did not introduce into the record the Texas Chiropractic Association guidelines that he had referenced in a letter to MRD hearing officer. Since they are not in evidence, the ALJ was unable to evaluate Provider's assertion that he met those standards.

[24] Provider Exh. 1, pp. 41-43.

Claimant's sex and age–presumably uninjured–was gripping or lifting of approximately 110 pounds. Claimant tested to 17.5 pounds by the end of November 2003, and to 51 pounds by the end of January 2004. Claimant's elbow range of motion–tested by a ROM inclinometer–moved from 30 per cent below full extension on October 27, 2003, to 15 per cent by mid-December 2003, to 10 per cent by the end of January 2004.[25] No functional capacity evaluation (FCE) was performed during the treatment period. Claimant's targets for improvement, if such were formulated, were not in evidence, so it is unknown whether Claimant's progress met or exceeded either personal goals or expected progress for the type of injury incurred.

Provider argued that the total treatment time (or units) was comparable to the time (or units) of a formal work conditioning program–about 480 units of service–so was not excessive treatment.[26]

Dr. Honigsfeld stated that approximately four weeks of post-operative therapy accompanied by a home exercise program would have been warranted by Claimant's condition. He stated that any extensive in-office therapy after that period of time would have been excessive treatment unless justified by testing results and that Provider's record did not include test results sufficient to support the need for the prolonged in-office therapy.

Dr. Honigsfeld also stated that chiropractic manipulation of the elbow would not be appropriate in treatment of a fractured joint and that application of analgesic balm had no long-term, lasting benefit and amounted to something that the Claimant could have done himself with over-the-counter medications. He also stated that conducting multiple sessions of one-on-one therapy for ROM improvement was inconsistent with recognized chiropractic practice standards.[27]

---

[25] Provider recommendation for a permanent impairment rating relies in significant part on the neuropathy, first diagnosed in February 2004, as well as the permanent ROM limitation of Claimant's left wrist and elbow. Provider Exh. 1, pp. 287-288.

[26] Provider's Argument, p. 6.

[27] Specific practice standards referenced were not in evidence, so the ALJ could not compare the treatment against those standards.

Provider billed for preparation of seven work status reports (99080-73) as provided in 28 TEX. ADMIN. CODE § 129.5. Five work status reports that were prepared by Provider were admitted into the record of this case. Carrier had denied reimbursement for six.

C. Analysis

Carrier's expert, Dr. Honigsfeld, acknowledged that Claimant required four weeks of post-operative therapy to regain his ROM in his left arm, although differing as to the appropriate method. Dr. Ogunro prescribed post-operative therapy. The first day of therapy appears to have been October 27, 2003. It is a reasonable inference that Claimant was healing from the surgery between October 4 and October 27, 2003, so therapy during that period would have been premature. Taken as a whole, the medical evidence is in fair agreement that up to a month of therapy was appropriate to treat Claimant's injury. As Claimant's treating doctor, Provider was in the best position to know what treatments were of benefit in Claimant's transition to fuller use of his elbow and return to work.

However, the continuation of essentially the same program, at the same level of intensity, for an additional two months did not have such support. Provider's treatment notes are virtual carbon copies of each other and, in large part, conclusory. Although Provider stated that the treatment allowed Claimant to advance rapidly to full duty, there is also some evidence that Claimant could have made similar gains in strength and ROM through less-intensive treatment. There was no general concurrence from Carrier's expert as for the early therapy. There appears to have been no home program administered and no clear documentation of why Claimant's need for a full battery of treatments did not dwindle over time as he improved. There were no individualized treatment goals or standards such as functional capacity guidelines against which Claimant's progress was measured.

The comparison of total time spent on this program as compared to a work conditioning program as an argument for continued therapy is simply misdirected as there is no evidence that

Claimant's medical needs compared in any way to those of a candidate for a work conditioning program.

Although some treatment was necessary, Provider failed to demonstrate that all treatment was provided as billed. Specifically, Provider's medical records fail to show that Provider's staff administered multiple units of one-on-one therapy on each of the twelve dates of service for which it was billed. The documentation to support the administration of the therapy was sketchy in terms of actual time and personnel involved for such extensive individualized treatment. Although the ALJ is persuaded that Provider administered physical therapy during those sessions, the ALJ cannot "downcode" to order reimbursement for services other than those billed. That being the case, the ALJ must conclude that Provider did not meet its burden of proof to show multiple units of *one-on-one* therapy were administered to Claimant so reimbursement must be denied.

Carrier did not put into issue the medical necessity of the passive components and the MRD did not decide the case on that issue, but rather on documentation. Daily treatment notes and reports state that the various modalities were provided on the scheduled dates for each treatment session, and that a TENS unit was dispensed or used to treat Claimant on January 30, 2004. Thus, Provider did document that these treatments were provided. However, Provider's records did not demonstrate the need for professional application of the analgesic balm or document the $15.00 value of the service.[28]

Provider should be reimbursed for the preparation of five work status reports. Without clarification from the Carrier as to what it meant by lack of documentation, the ALJ concludes that Carrier was simply arguing that Provider had not prepared them. Clearly, he did, so should be reimbursed for them.

There are some significant variations between the course of therapy here and the requirements of the 2002 MFG. For example, there was no treatment regimen outlined by the physician, nor was therapy limited to 30 to 45 minutes per session. However, the treatment was directed to a specific

[28] 1996 MFG, pp. 1-2.

goal, improving Claimant's arm ROM, and was more than maintenance therapy to support existing functioning of the limb.[29] The ALJ concludes that a month of post-surgical therapy directed to restoring Claimant's left arm ROM is not inconsistent with the general physical therapy guidelines referenced by the 2002 MFG. The ALJ is unpersuaded that it would be fair to either Party to reconfigure in detail the fundamental terms of the dispute at this late stage of the process when the record of this case showed that *neither* Party appeared to have contemplated or used these guidelines in making and reviewing these claims.

D. Summary

The ALJ concludes that Carrier should reimburse Provider for most therapy administered by Provider through November 27, 2003. Therapy administered after that period of time should not be reimbursed. No sessions of one-on-one physical therapy administered should be reimbursed. Ultrasound, electrical muscle stimulation, and use or dispensing of a TENS units were provided as billed so should be reimbursed. To the extent any service was billed above MAR, the reimbursement should be reduced to the MAR for that procedure as it appears in the 1996 MFG. The need for professional application of an analgesic balm required more complete documentation than was provided so should not be reimbursed.

Carrier should reimburse Provider for preparation of five work status reports during the treatment period.

II. FINDINGS OF FACT

1. On ___, ___ (Claimant) injured his left elbow in a fall from a scaffold.

2. Employers Mutual Casualty Company (Carrier) was the responsible insurer.

[29] *See* discussion of CMS guidelines on physical therapy. SOAH Dkt. 453-04-6623.M5.

3. Claimant suffered a comminuted (splintering) fracture of the radial head of his left elbow and a fracture of the coronoid process of his left elbow.

4. Claimant also suffered a temporary ulnar motor mononeuropathy of the left elbow.

5. On October 4, 2003, E. Olayinka Ogunro, M.D., extracted bone fragments from Claimant's elbow and fixed the elbow joint by two internal screws inserted into the joint.

6. Patrick Davis, D.C. (Provider), was Claimant's treating doctor beginning October 15, 2003, and had referred Claimant for orthopedic examination.

7. Dr. Ogunro prescribed post-operative therapy to improve Claimant's range of motion (ROM) of his left arm.

8. Dr. Ogunro did not prescribe a specific a course of rehabilitative therapy or the expected length of such therapy; he did not oversee the rehabilitation treatment administered by Provider.

9. Provider began post-operative treatment and rehabilitation of Claimant on October 27, 2003, the end of Claimant's post-operative recovery period.

10. Between October 27, 2003, and January 30, 2004 (treatment period), Provider conducted 46 treatment sessions, each of which comprised both active therapy and passive modalities.

11. For each treatment session, Provider sought reimbursement for some or all of the following: extremity manipulation (98943), myofascial release and manual traction (97140), neuromuscular reeducation (97112), one-on-one therapeutic procedures (97110), ultrasound (97035), electrical muscle stimulation (97032), kinetic procedures (97530), and the application of a topical analgesic (99070).

12. On January 30, 2004, the date of Claimant's last office visit, Provider dispensed a TENS unit to Claimant or treated him with a TENS unit.

13. During the treatment period, Provider prepared five work status reports on Claimant's readiness to return to work.

14. Post-surgical rehabilitation for up to four weeks was necessary to improve Claimant's ROM after the elbow surgery.

15. The gripping or lifting strength of Claimant's left hand or arm went from 17.5 pounds at the end of November 2003 to 51 pounds by the end of January 2004.

16. Claimant's elbow ROM was tested by a ROM inclinometer and moved from 30 per cent below full extension on October 27, 2003, to 15 per cent by mid-December 2003, to 10 per cent by the end of January 2004.

17. No functional capacity evaluation (FCE) was performed during the treatment period.

18. Claimant's absolute improvement in lifting or grip strength, ROM, and improved movement against resistance during the treatment period was not compared to any standards for persons with similar injuries.

19. Claimant's rate of improvement in lifting or grip strength, ROM, and improved movement against resistance during the treatment period was not compared to any standards for persons with similar injuries.

20. Provider's documentation did not show individual treatment goals or record Claimant's progress toward meeting his individual treatment goals or objectives.

21. Provider did not document performance by Claimant of a home exercise program.

22. Neither the need for the application by health care providers of an analgesic balm nor the reasonableness of the cost was documented.

23. Claimant was returned to light duty, with lifting restrictions, during the treatment period, with return to duty without restrictions at the end of January 2004.

24. Carrier denied payment for all extremity manipulation, myofascial release and manual traction, neuromuscular reeducation, and kinetic procedures on the basis they were not medically necessary.

25. Carrier denied payment for one-on-one therapeutic procedures on the basis that Provider billed amounts above the maximum allowable reimbursement (MAR) set in the 1996 *Medical Fee Guideline* (MFG), 28 TEX. ADMIN. CODE § 134.201.

26. Carrier denied payment for ultrasound, the application of a topical analgesic, electrical muscle stimulation, and the dispensing or use of the TENS unit on the basis that Provider had failed to document the provision of the treatment as billed and had billed amounts above the MAR set in the 1996 MFG.

27. Carrier denied payment for the preparation of the work status reports on the basis that Provider had not documented the provision of the service as billed.

28. Provider sought review by the Medical Review Division (MRD) of Texas Worker's Compensation Commission (TWCC or Commission) of all Carrier's denials of payment.

29. On November 2, 2004, an Independent Review Organization (IRO) reviewer stated that post-surgical rehabilitation, although not passive modalities, would be medically necessary to treat Claimant after an elbow surgery.

30. On January 14, 2005, the MRD denied further reimbursement to Provider for extremity manipulation, myofascial release and manual traction, neuromuscular reeducation, and kinetic procedures administered to Claimant during the treatment period on the basis the services were not medically necessary.

31. On January 14, 2005, the MRD denied further reimbursement to Provider for one-on-one physical therapy, ultrasound, the application of a topical analgesic, electrical muscle stimulation, and the dispensing or use of the TENS unit on the basis that Provider had failed to document provision of the treatments as billed.

32. On January 14, 2005, the MRD denied further reimbursement to Provider for preparation of six work status reports on the basis Provider had not documented provision of the service as billed.

33. On January 27, 2005, Provider requested a hearing on the MRD Decision.

34. On February 16, 2005, the Commission issued a notice of hearing that included the date, time, and location of the hearing, the applicable statutes under which the hearing would be conducted, and a short, plain statement of matters asserted.

35. Administrative Law Judge Cassandra Church conducted a hearing on the merits on April 25, 2005, and closed the record on June 1, 2005, to permit Parties to review and submit legal authority and argument.

III. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. §413.031 and TEX. GOV'T CODE ANN. ch. 2003.

2. Provider timely requested a hearing, as specified in 28 TEX. ADMIN. CODE §148.3.

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

4. Provider, as the petitioning party, has the burden of proof in this proceeding pursuant to TEX. LAB. CODE ANN. § 413.031, 1 TEX ADMIN. CODE § 155.41(b), and 28 TEX. ADMIN. CODE ' 148.14(a).

5. Provider met its burden of proof to show that elbow rehabilitation and treatments provided in support of that rehabilitation between October 27, 2003, and November 27, 2003, were medically necessary to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§ 408.021 and 401.011(19).

6. Provider met its burden of proof to show he prepared and appropriately billed for five work status reports in accordance with 28 TEX. ADMIN. CODE §129.5(d).

7. Provider failed to meet its burden of proof to show that extremity manipulation, myofascial release and manual traction, neuromuscular reeducation, and kinetic procedures were medically necessary for any dates after November 27, 2003, to treat or reasonably required to relieve the effects of or promote recovery from a compensable injury suffered by Claimant, within the meaning of TEX. LAB. CODE ANN. §§ 408.021 and 401.011(19).

8. Provider failed to meet its burden of proof to document that one-on-one physical therapy, was provided and billed in accordance with 28 TEX. ADMIN. CODE §§ 134.201 (1996 MFG) and 134.202 (2002 MFG) for any date of service within the treatment period.

9. Provider met its burden of proof to show that passive modalities, including ultrasound, electrical muscle stimulation, and the dispensing or use of a TENS unit were provided during the treatment period and billed in accordance with the 28 TEX. ADMIN. CODE § 134.201 (1996 MFG).

10. Provider failed to meet its burden of proof to document that application of a topical analgesic was provided and billed in accordance with 28 TEX. ADMIN. CODE § 134.201 (1996 MFG) on any date within the treatment period.

ORDER

IT IS ORDERED that Employers Mutual Casualty Company is hereby ordered to reimburse Patrick Davis, D.C., for all treatments, except any sessions of one-on-one physical therapy, provided to Claimant between October 27, 2003, and November 27, 2003, for five work status reports, and for ultrasound treatments, electrical stimulation, and the use or dispensing of a TENS unit between October 27, 2003, and January 30, 2004. Any reimbursement shall be at the MAR for that treatment as listed in the 1996 Medical Fee Guideline.

IT IS FURTHER ORDERED that all other requests for reimbursement for services provided for Claimant between November 28, 2003, and January 30, 2004, including any sessions of one-on-one physical therapy and for application of analgesic balm are hereby denied.

SIGNED August 1, 2005.

_____

CASSANDRA J. CHURCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS