SOAH DOCKET NO. 453-05-7153.M5
MRD NO. M5-05-1327-01

PARKER CHIROPRACTIC CLINIC, D.C.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
TEXAS MUTUAL INSURANCE	§	
COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondent	§	

DECISION AND ORDER

I. INTRODUCTION

This case presents a challenge by Parker Chiropractor Clinic (Provider) to a decision of an independent review organization (IRO) on behalf of the Texas Department of Insurance, Division of Workers' Compensation,[1] in a dispute regarding medical necessity for chiropractic treatment. The IRO found that the insurer, Texas Mutual Insurance Company (Carrier), properly denied most of the reimbursement for chiropractic services that Provider administered to a claimant suffering from back and left knee work injury, with the exception of reimbursements in the amount of $272.96. The Medical Review Division (MRD) recommended $554.23 of additional fee dispute services be paid, but generally agreed with the IRO that Carrier properly denied most of the reimbursement.

Provider challenges the decision on the basis that the treatment at issue was, in fact, medically necessary, within the meaning of §§ 408.021 and 401.011(19) of the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. ch. 401 *et seq.*

This decision finds that some additional reimbursements are warranted beyond what was allowed by the IRO and MRD, but finds that all reimbursement requests requiring one to one supervision were excessive and not supported by the evidence.

[1] Formerly the Texas Workers' Compensation Commission.

II. JURISDICTION AND VENUE

The hearing in this docket was convened on January 31, 2006, at the State Office of Administrative Hearings (SOAH) facilities in the William P. Clements Building, 300 W. 15th St., Austin, Texas. Administrative Law Judge (ALJ) Bill Zukauckas presided. Provider was represented by James W. Parker, D.C. Carrier was represented by attorney Ryan Willett. The record closed on March 21, 2006, after closing arguments were submitted.

No party challenged jurisdiction or venue. Therefore, those matters are set out in the findings and conclusions without further discussion here.

III. STATEMENT OF THE CASE

Claimant suffered an injury to his back and left knee from falling off a ladder on___. According to the IRO decision, "claimant received no initial care at an emergency room or from any other physician until 1/17/03." He received eight weeks of therapy at Rehab First from March 31 - May 23, 2003, where he was treated with a variety of active exercises and passive modalities. As a result of a designated doctor exam, Dr. Martin Jones placed claimant at clinical Maximum Medical Improvement (MMI) as of July 5, 2003 with a 0% whole person impairment. Claimant began therapy at Parker Chiropractic on November 2, 2003, approximately six months after his therapy at Rehab First ended. The dates of service in dispute in this matter are January 7, 2004 - April 22, 2004.

Carrier denied reimbursement on the grounds that the treatment had been medically unnecessary. Provider sought medical dispute resolution through the Commission. The IRO to which the Commission referred the dispute issued a decision on April 25, 2005, concluding that Provider should not receive reimbursement for most of the disputed services. The IRO presented the following rationale for its decision:

> At the beginning of 2003, the claimant underwent an extensive trial of physical therapy to his left lower extremity to try to help improve his symptoms. The claimant then went approximately 6 months with no medical treatment before

> deciding to change to Dr. Parker for future treatment. It appears the claimant had not had any treatment for his lumbar spine which appears to have been effectively addressed in November and December 2003. Beyond that time ongoing therapy for the lumbar spine is not seen as reasonable or medically necessary. The MRI performed by Dr. Parker revealed the claimant did have injuries to his left meniscus and future treatment options may have been necessary. Continued and ongoing therapy is not considered reasonable or medically necessary because conservative therapy had been tried and failed in the beginning of 2003. Monthly office visits to monitor the claimant's condition as well as referrals are considered medically necessary. The remainder of the therapy rendered between 1/7/04 through 4/22/04 appears redundant and is not objectively supported by the documentation supplied. Although the treating physician reported the claimant had many subjective complaints, the exam performed on 10/13/03 by Dr. Jones revealed no positive drawer, negative McMurray's test, no pain or laxity with medial and lateral stress. Dr. Jones noted there was no swelling, no skin changes or tenderness noted in the knee as well as the left lower extremity with the exception of some ill defined tenderness noted in the knee as well as the left lower extremity with the exception of some ill defined tenderness over the proximal anterior foot. Range of motion appeared grossly normal. With no positive orthopedic findings on 10/13/03, there is no objective documentation in the entire file reviewed that would support therapy dated 1/7/04 that continued through 4/22/04.

The IRO ruled that the therapeutic activities (CPT Code 97530), electrical stimulation (G0283), therapeutic exercises (97110), group therapeutic procedures (97150), unusual special service (translation) (99199), hot/cold pack (97010), self care management training (97535), and unlisted modality (97039) were not medically necessary.

The Commission's Medical Review Division (MRD) reviewed the IRO's decision and, on May 5, 2005, issued its own decision confirming that the disputed services were generally not medically necessary with the exception of $554.23 of additional services. Provider then made a timely request for review of the IRO and MRD decisions before SOAH.

IV. THE PARTIES' EVIDENCE AND ARGUMENTS

A. Provider

Provider took issue with the IRO's conclusions in this case. Provider argues that overall, claimant benefitted from the services rendered. Provider believes the evaluation of the medical

services he provided should consider a broad range of measures including the "Dallas" disability questionnaires, the functional improvement in strength, the resolution of multiple objective findings, the overall lessening of subjective complaints, and most importantly -- the transition from "intractable pain and disability," to light duty work and the eventual return to full duty employment.

With regard to physical exams, Provider compares November 3, 2003, January 14, and February 25, 2004. He notes that for the first exam, pain was provoked with five activities: sneezing, lifting, bending, sitting and standing and that claimant exhibited frequent urination. He represented that claimant exhibited three orthopedic findings – which are tests used to yield information by provoked painful responses. By January 14, 2004, claimant's pain was provoked by only four activities: lifting, bending, standing, and walking. Frequent urination symptoms had disappeared by this date, and claimant had four orthopedic findings. By February 25, 2004, claimant's pain was provoked by only two activities and he only had one orthopedic finding. Provider argues that this shows while gains were mild from November to January, they were substantial from January to the end of February.

With regard to physical performance evaluations, Provider references two dates from before the dates of service at issue, November 13, 2003 and December 22, 2003, to show claimant was making improvements. On November 13, 2003, Provider says three timed tests were used to evaluate claimant's ability to use his back. His strength scores were 52.1 lbs. for the low (leg) lift, 31.1 lbs. for the middle (arm) lift, and 28.0 lbs., for the high lift. On the Dallas Pain Questionnaire, Daily Activity score was 60%, Work Activities was 75%, Anxiety was 5%, and Social Interest was 10%. On December 22, 2003, the Provider argues claimant had made overall progress on these same tests. For that session, his strength scores were 58.0 lbs. for the low (leg) lift, 45.4 lbs. for the middle (arm) lift, and 47.2 lbs. for the high lift. On the Dallas Pain Questionnaire, Daily Activity score was now 48%, Work Activities was 65%, Anxiety was 0%, and Social Interest was 10%. Provider notes that both the perceived disabilities and overall strength improved from November to December, showing improvement in claimant's overall condition.

Provider believes the most important issue is that claimant went from being in intractable pain and not working on October 30, 2003, to working with restrictions (lifting no more than 15 lbs.)

on January 21, 2004, to returning to work without restrictions by March 15, 2004. Provider argues, and notes that Carrier's expert agreed, that his services that helped claimant return to work after 18 months of complete disability and believes this is just the sort of improvement contemplated by Section 408.021 of the Code.

Provider argues that one-on-one supervision was necessary for this patient most for most of the sessions. Where one-on-one therapy was unnecessary, it billed using a group code. Provider argues that better results are obtained with close supervision. It also argues that the total length of treatment per session and total days of treatment were reasonable under most worker rehabilitation standards. Provider believes that the Medicare guideline are for older patients needing shorter term rehabilitation and not returning to a heavy duty job demand requirement.

B. Carrier

Carrier's expert witness, Dr. David Alvarado, provided expert testimony in support of the IRO decision that the disputed services were not medically necessary. Dr. Alvarado agreed with the IRO's rationale that claimant's lumbar spine injury was "effectively addressed in November and December 2003" and that "[b]eyond that time ongoing therapy for the lumbar spine is not seen as reasonable or medically necessary." While claimant began therapy at Parker Chiropractic on November 3, 2003, the time period for this dispute does not begin until January 7, 2004. Dr. Alvarado testified that the treatment provided by Provider for over two months prior to the first disputed date of service in this matter was more than an adequate trial of care for this claimant's lumbar spine injury,[2] and agreed with the IRO's rationale that "[t]he remainder of the therapy rendered between 1/7/04 through 4/22/04 appears redundant and is not objectively supported by the documentation supplied."

Carrier responded to Petitioner's argument that Dr. Alvarado focused solely on Claimant's subjective pain ratings and range-of-motion exams in forming his opinion that Petitioner's treatment was not medically necessary and disagrees with that assertion. Carrier notes while it is true that

[2] During this time period, Petitioner was treating claimant four times per week.

Dr. Alvarado emphasized that claimant's subjective pain ratings remained virtually the same during the entire six-month period of therapy, these were not the only factors in forming his opinion.[3]

Carrier disagrees with Petitioner's assertion that Dr. Alvarado failed to review other factors which allegedly indicate claimant's improvement, starting with the Dallas Pain Questionnaire, which was given to claimant on November 13 and December 22, 2003. Carrier argues that this questionnaire shows minimal improvement by claimant, as his Daily Activities improve from 60% to 48%, his Work/Leisure Activities improve from 75% to 65%, his Anxiety/Depression improves from 5% to 0%, and his Social Interest remains the same over a six-week period. Carrier also notes that Section III of this questionnaire reveals that claimant actually noticed more limitation in lifting on December 22, 2003 than he did on November 13, 2003, after six weeks of therapy. This is in direct contrast to the findings of the December 22, 2003 follow-up physical performance exam. According to Deanna Gray, claimant's lifting ability improved 35.4% from the prior exam on November 13, 2003. While Petitioner's examination of claimant appears to indicate he improved his lifting capacity, Carrier argues that claimant's own words directly contradict those findings. Therefore, Carrier argues Petitioner has not met its burden on this issue.

Carrier notes that while Dr. Alvarado did discuss the Dallas Pain Questionnaire, Petitioner fails to mention the Oswestry low back pain disability questionnaire, which was also given to claimant on November 13 and December 22, 2003. Carrier notes that a review of these questionnaires shows that claimant not only scored the same on both dates, but gave the exact same answers to every question. As Dr. Alvarado testified, Carrier argues this shows the lack of improvement over a six-week period prior to the disputed dates of service, and is further evidence that continued therapy was not medically necessary.

Finally, Dr. Alvarado also cited the results of the examination of claimant performed by Anthony G. Bascone, D.O., on October 31, 2003, which showed normal findings for claimant's cervical spine, thoracic spine and lumbar spine. *See* TMI 231. For each area, the resulting

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During the merits hearing, Carrier notes that Petitioner's representative attempted to show claimant's subjective improvement by pointing out several dates on which claimant's rating dipped to 3/10. Carrier argues that these were mere aberrations, as claimant only rated his pain as a 3/10 on six dates of service during the six *months* of treatment from Parker Chiropractic. Carrier also believes it is important to note that careful review reveals that on five of the six instances in which claimant's rating dipped to 3/10, his rating returned to 5/10 by the next date of service. *See* TMI 252-473.

impression showed "contour of the vertebral column is satisfactory" and "no evidence of fracture or dislocation." *Id*. The only other notation on the exam was "mild degenerative changes" in the thoracic spine. *Id*.

C. Petitioner's Treatment of Claimant's Knee Injury

Carrier notes that Dr. Alvarado also agreed with the IRO's rationale concerning Parker Chiropractic's treatment of claimant's knee injury, which states "[c]ontinued ongoing therapy is not considered reasonable or medically necessary because conservative therapy had been tried and failed in the beginning of 2003." *Id*. As stated above, claimant received eight weeks of therapy at Rehab First from March 31 - May 23, 2003. A review of the clinical notes from Rehab First during this time shows that claimant's therapy consisted of a variety of passive and active modalities for his knee, including electrical stimulation, hot/cold packs and therapeutic exercises. *See* TMI 176-223. These are some of the same services in dispute in this matter. Despite Petitioner's attempts to depict its treatment of claimant as different and medically necessary, Carrier argues the records show it was the same "conservative therapy" that "had been tried and failed in the beginning of 2003." IRO Decision, TMI 7.

Carrier also notes the findings by Dr. Martin Jones as evidence that Parker Chiropractic's treatment was not medically necessary. Dr. Jones placed claimant at clinical MMI as of July 5, 2003 with a 0% impairment rating. Even assuming Dr. Jones' exam and findings were limited to claimant's knee, as Petitioner suggests, Carrier argues it rules out any medical necessity for treatment to claimant's knee during these disputed dates, which begin over six months after the MMI date. Carrier contends Dr. Alvarado's testimony about Dr. Jones' exam and the records support a finding that any of Petitioner's treatment during the disputed dates for the benefit of claimant's knee rather than his back, was not medically necessary.

D. Specific Services

Carrier notes that a significant portion of the services in dispute in this case consists of one to one therapeutic exercises and therapeutic activities (CPT Codes 97110 and 97530, respectively).

Carrier argues that it is important to distinguish between the medical necessity of some form of physical therapy and the medical necessity of the level of physical therapy provided by Petitioner. Carrier believes that the evidence does not document that the patient required physical therapy services in a one to one setting. As Dr. Alvarado testified, physical therapy exercises can be performed in a variety of settings. The most intensive setting is one to one attendance. In this setting the patient is attended exclusively by a health care provider and monitored throughout the duration of exercise. The next most intensive setting is the group therapy setting (CPT Code 97150). In this setting, the patient is also attended constantly, but the therapist is supervising two or more patients. Finally, a patient may perform physical therapy exercises in an independent home exercise program. Carrier notes that of the exercises and activities administered in a one to one setting could be performed in a group setting or in a home exercise program.

E. One to One Attendance Was Not Shown to be Medically Necessary for Instruction or Safety

Dr. Alvarado testified briefly regarding the circumstances that make one to one attendance medically necessary. First, Dr. Alvarado testified that a one to one setting is appropriate to instruct the patient in how to perform the exercises. According to Dr. Alvarado, these could be learned and practiced in just a few visits, and then performed in an environment less intensively supervised than a one to one setting. Carrier's records show that claimant began performing therapeutic exercises on November 24, 2003, over six weeks prior to the first disputed date of service in this matter. *See* Petitioner's Exhibit A, pp. 138-39. Carrier argues that the only expert testimony in the record from Dr. Alvarado indicated there is no instructional purpose for one to one therapy over the course of months with little alteration to the patient's program.

Carrier also notes that Dr. Alvarado testified that the safety of the patient may be a basis for performing the physical therapy in a one to one, constant attendance environment. However, a review of the exercises performed by claimant shows that the patient's safety was not implicated, according to Dr. Alvarado. Further, Carrier argues there is no documentation in Petitioner's records of falls, dizziness, or any indication that these exercises posed any risk to the patient's safety. From November 24, 2003 forward, claimant performed at least an hour of exercise per visit with no mention of any safety risk to him.

F. Passive Modalities in a Chronic Patient are not Medically Necessary

Carrier argues that Dr. Alvarado's testimony indicated passive modalities are used for the treatment of acute injury and that nothing in Petitioner's records explains why passive modalities were being utilized 15 months after the date of injury and over two months into the treatment regimen.

G. Fee Disputes

Carrier maintains the same position on the fee dispute issues as it does on the medical necessity dispute in that Petitioner has failed to meet its burden of proof on these issues to overturn the decision by the MRD. Carrier argued that because Petitioner did not provide any testimony or submit any additional significant documentary evidence at the merits hearing, the MRD decision should be affirmed.

V. ANALYSIS

A. General Findings

The ALJ finds Provider has shown that some of its services were medically necessary for treatment of Claimant's back injury from his compensable injury, but that the treatment seemed excessive based on the documentation and expert testimony in the case. Nonetheless, the ALJ has tried to give Provider some credit for services provided because the evidence indicates they were ultimately helpful in returning claimant to work.

The ALJ notes that Provider was procedurally disadvantaged by its own actions in this matter. Carrier made a good-faith effort to prepare for hearing and depose Petitioner's principal, Dr. Parker. At the deposition, Dr. Parker refused to answer any deposition questions for reasons he did not explain. Consequently, the ALJ sustained an objection to his attempt to provide expert testimony at the hearing. While Provider attempted to make his case through cross-examination of the Carrier's expert and through closing arguments, Provider's case lacked explanatory expert

testimony supporting his issues, particularly with regard to duration and frequency of treatment.

The ALJ accepts Dr. Alvarado's testimony that other factors, such as the Dallas Pain Questionnaire, given to claimant on November 13 and December 22, 2003, show minimal improvement by claimant. And as Carrier correctly notes, Section III of this questionnaire reveals that claimant actually noticed more limitation in lifting on December 22, 2003 than he did on November 13, 2003, after six weeks of therapy. The ALJ agrees that this seems to inexplicably contradict the findings of the December 22, 2003 follow-up physical performance exam saying that claimant's lifting ability improved 35.4% from the prior exam on November 13, 2003, because claimant's own words directly contradict those findings. That being said, bottom line results matter and Provider's services seemed to be responsible for getting claimant back on the job. As Provider notes, claimant was out of work for 18 months before Provider's treatment returned him to work. For 15 months before Provider's treatments, claimant was unable to return to work and some part of the intervening therapies seemed to have rehabilitated him for work. The ALJ believes some of the treatments, although possibly helpful, were excessive based on the evidence and documentation.

B. Specific Findings For CPT Codes

The ALJ finds that all services in dispute in this case involving one to one therapeutic exercises and therapeutic activities (CPT Codes 97110 and 97530, respectively), are disallowed. There was no evidence to support the large multiple units of these codes billed per date. Also, there was no documentation of special safety needs for claimant. Conversely, the CPT Code 97150 for therapeutic group activities was somewhat more reasonably billed and easier to justify. The ALJ orders it paid for each day of service, whether it has a modifier at the end or not.

The ALJ agrees with Carrier that the overall billing for the office visits was excessive. The ALJ finds that CPT Code 99213 should be reimbursed for four dates of service as described by the IRO decision and that all other dates for that code or CPT Code 99214 are disallowed.

The ALJ finds that CPT Code G02 83- electrical stimulation unattended, 99199 - unusual special service (translation), 97010 - hot/cold pack, 97535 - self care management training, and 97039 - unlisted modalities, should be paid for each date of service. The ALJ believes these services

were clearly rendered and at a reasonable cost. It is hard for the ALJ to know if a translator was needed each time Provider billed for one, but the ALJ does not doubt that one was present. The ALJ also sees documentation from another provider suggesting communication with claimant was difficult. Likewise, while there was some evidence that passive modalities like hot/cold packs and electrical stimulation might be late in the process, the ALJ does not doubt they were provided, believes they were provided at a reasonable cost, and orders them to be paid.

The ALJ finds that CPT Code 99499 and 99499-52 were reasonable for all dates of service. Provider described documentation of procedure on all dates. The ALJ does not know if the -52 suffix modifier is technically correct for the code, but understands what Provider intended and orders this service paid.

The ALJ agrees with the MRD findings for CPT Codes 99204 and 99214 and orders those paid per the calculation in the MRD order.

The ALJ finds CPT Code 99358-52 for prolonged physician contact without direct (face-to-face) patient contact to be reasonable, at the reduced billed rate of $40.00 for February 19, and March 19 and 22, 2004. Again, the ALJ is not sure whether the -52 modifier is appropriate, but understands what Provider has done and orders all of these paid at the rate billed.

VI. FINDINGS OF FACT

1. Claimant suffered a back and left knee injury from falling off a ladder on___, which constituted a compensable injury under the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. § 401.001 *et seq*.

2. Claimant received eight weeks of therapy at Rehab First from March 31 - May 23, 2003, where he was treated with a variety of active exercises and passive modalities.

3. As a result of a designated doctor exam, Dr. Martin Jones placed claimant at clinical Maximum Medical Improvement (MMI) as of July 5, 2003 with a 0% whole person impairment. That finding considered only claimant's knee injury.

4. Claimant began therapy with Petitioner on November 2, 2003, almost six months after his therapy at Rehab First ended.

5. The dates of service in dispute in this matter are January 7, 2004 - April 22, 2004.

6. Claimant has never undergone any surgery for his injuries.

7. Carrier denied the requested reimbursement.

8. Provider made a timely request to the Texas Workers' Compensation Commission (Commission) for medical dispute resolution with respect to the requested reimbursement.

9. The independent review organization (IRO), to which the Commission referred the dispute, issued a decision on April 25, 2005, finding, generally, that the treatment at issue was not medically necessary. The IRO ruled that the therapeutic activities (CPT Code 97530), electrical stimulation (G0283), therapeutic exercises (97110), group therapeutic procedures (97150), unusual special service (translation) (99199), hot/cold pack (97010), self care management training (97535), and unlisted modality (97039) were not medically necessary with the exception of $272.96 of services.

10. The Commission's Medical Review Division (MRD) reviewed and concurred with the IRO's findings in a decision dated May 5, 2005, and found an additional $554.23 of services classified as fee disputes should be paid.

11. Provider timely requested a hearing with the State Office of Administrative Hearings (SOAH), seeking review and reversal of the MRD decision regarding reimbursement.

12. The Commission mailed notice of the hearing to all parties.

13. A hearing in this matter was convened on January 31, 2006, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Bill Zukauckas, an Administrative Law Judge with SOAH. The record closed on March 21, 2006.

14. The services rendered by Provider helped treat claimant's lower back pain and help him return to work.

15. Although the one to one services billed under CPT Codes 97110 and 97530 may have been helpful to claimant, there was no documentation to show that they addressed any exercise training goal or safety concern for this claimant.

16. The services billed under CPT Codes 97110 and 97530 were excessive based on the documentation in the record.

17. The CPT Codes listed below were medically necessary as limited and described below:

    a. There was sufficient documentation to show the necessity of CPT Code 97150 for therapeutic group activities, whether or not it has a modifier at the end of the code.

    b. CPT Code 99213 should be reimbursed for four dates of service only. All other dates for that code or CPT Code 99214 are disallowed because they were excessive

without documentation of special circumstances.

c. CPT Code G0283- electrical stimulation unattended, 99199 - unusual special service (translation), 97010 - hot/cold pack, 97535 - self care management training, and 97039 - unlisted modalities, were medically necessary and billed at a reasonable price for each dates of service.

d. Translation services were needed for this particular claimant and the rate billed by Provider for this service was reasonable.

e. CPT Code 99499 and 99499-52 were reasonable for all dates of service because Provider described documentation of procedure on all dates.

f. CPT Codes 99204 and 99214 were reasonable and should be paid per the calculation in the MRD order.

g. CPT Code 99358-52 for prolonged physician contact without direct (face-to-face) patient contact was reasonable, at the billed rate of $40.00 for February 19, and March 19 and 22, 2004.

VII. CONCLUSIONS OF LAW

1. The Division of Workers' Compensation of the Texas Department of Insurance has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. §413.031.

2. 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 §§413.031(k) and 402.073(b) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules.

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

5. Provider, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.14(a).

6. Based on Findings of Fact Nos. 15 and 16, none of Provider's one to one services were medically necessary for the dates of services at issue. These represent a majority of the dollar services billed.

7. Based on Finding of Fact No. 17, some of the services rendered were medically necessary.

ORDER

IT IS THEREFORE ORDERED that Parker Chiropractic Clinic, D.C., should receive reimbursement from Texas Mutual Insurance Company (Carrier) for those items previously ordered by the IRO and MRD, and additionally for the CPT Codes described and limited in Finding of Fact No. 17.

SIGNED May 17, 2006.

BILL ZUKAUCKAS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS