SOAH DOCKET NO. 454-10-2110.M4

Petitioner	§	**BEFORE THE STATE OFFICE**
	§	
	§	
V.	§	**OF**
	§	
TPS JOINT SELF INSURANCE FUND,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER
ON MOTION FOR SUMMARY DISPOSITION

The TPS Joint Self Insurance Fund (Carrier) filed a motion for summary disposition, contending that there was no legal basis for . (Claimant)[1] to have a review of his claim for reimbursement because Carrier no longer has any liability for payment of disputed medical fees and because Claimant exhausted his administrative remedies to assert the medical necessity for the disputed procedure. Claimant opposed the motion, contending that there was a basis for Claimant to have a retrospective review of medical necessity under the facts in this case. Carrier requested that Claimant's case be dismissed. Claimant requested that the Texas Department of Insurance, Division of Workers' Compensation (TDI/Division) be ordered to assign an independent review organization (IRO) to evaluate the medical necessity for Claimant's treatment and consequent claim for reimbursement.

The Administrative Law Judge (ALJ) concluded that there was no dispute as to material facts and that Carrier was entitled to a decision as a matter of law. Based on that decision, the ALJ finds that Petitioner's case should be dismissed as the Division acted correctly in denying further review of Claimant's request for reimbursement on the basis that the medical necessity for the procedure had been previously resolved.

[1] Notwithstanding the designations in the style of the case, the injured worked is styled "Claimant" in administrative pleadings, so that designation will be kept here for clarity.

I. PROCEDURAL HISTORY AND RULINGS

In December 2009, Claimant requested a contested case hearing on the Division's decision to deny his request for a retrospective IRO review. On January 11, 2010, the Division issued a notice of hearing. On January 20, 2010, Carrier filed a motion for summary disposition, and Claimant replied on February 19, 2010. Both parties filed responses. On March 12, 2010, having considered the parties' positions and the applicable law, the ALJ concluded that the matter could be resolved on the basis of the parties' pleadings.

As neither party objected to the documents submitted by the other in support of their position on the summary disposition motion, all exhibits attached to the parties' motions are hereby admitted for purposes of considering this motion and deriving the Findings of Fact below. The ALJ also takes official notice of pleadings filed in the contested case at the State Office of Administrative Hearings (SOAH).

Claimant represented himself, with the assistance of Anthony Walker of the Ombudsman Services of the Division. Timothy R. White represented the Carrier.

Undisputed facts in the case are set out in the Findings of Fact below. Jurisdiction and notice were not disputed, so are set forth in the Findings of Fact and Conclusions of Law below.

II. DISCUSSION

A. Background

In . ., Claimant injured his back. In October 2008, Claimant requested preauthorization from Carrier for a plasma disc decompression at the L5-S1 level of the spine (the decompression procedure).[2] This is a surgical procedure that required preauthorization under the Division's rules. Carrier denied preauthorization, and the IRO reviewer also declined to approve the

[2] Plasma disc decompression is a means of decompressing vertebral discs by means of radiofrequency energy. The Official Disability Guidelines (ODG) has classified this as a "not recommended" procedure. Claimant Ex. C, p. 6.

procedure on December 23, 2008. Claimant appealed this decision by requesting a contested case hearing (CCH) to be conducted by a Division hearing officer.

The CCH hearing officer had not yet rendered a decision at the time Claimant underwent and paid out-of-pocket for the decompression procedure. The procedure was perfromed on January 30, 2009. The expenses for the procedures and related costs, including hospital fees, totaled $6,609.90.[3] Following administration of the procedure, Claimant sought reimbursement from Carrier for all of his out-of-pocket expenses.

In March 2009, the CCH hearing officer dismissed the claim as being outside its jurisdiction. Carrier successfully argued that the Division lost jurisdiction of the case once Claimant underwent the procedure and paid the service providers an amount in excess of $3,000, the upper jurisdictional limit for Division appeals.

After dismissal of the CCH, Claimant initiated a medical dispute resolution (MDR) hearing; the hearing officer upheld Carrier's denial. Claimant requested a contested case hearing at SOAH on the adverse MDR decision, but later withdrew his request on the basis that the underlying agency proceeding, the MDR, was not applicable to medical necessity issues.[4]

In December 2009, Claimant sought a second IRO review of the medical necessity of the procedure. The Division denied this request, declining to assign an IRO reviewer to Claimant's case. In denying the request, the Division stated that retrospective review of medical necessity was not appropriate for a procedure that required, and had been denied, preauthorization.[5] The Division did not, however, specifically cite to one of the six rules for denial of an IRO request set out in the Division's rules.[6] Claimant sought a contested case hearing regarding that decision. That hearing request was referred to SOAH, resulting in the instant case.

---

[3] Various documents reference amounts in controversy ranging from "about $5,100" to $6,942.80. The amount used in this Decision appeared in the MDR Decision that was issued in regard to this controversy. Carrier Exs. B and D, Claimant Ex. 6.

[4] Claimant Ex. 3.

[5] Carrier Ex. A.

In the instant case, Claimant asserted that he had presented sufficient indications of a medical emergency to support an IRO review, and that the Division erred in denying his request. Specifically, Claimant relied on his answer to a discovery question in which he stated that his condition had worsened by the date of the surgery to the point that he could not function at all.[7] The answer did not indicate over what period of time this deterioration had occurred.

B. Parties' Positions

Carrier contended that there was no legal basis on which Claimant could obtain a review of the medical necessity for the decompression procedure. Carrier said that, by law, Carrier's liability ended once Claimant underwent a surgical procedure that was required to have, but did not have, preauthorization. Carrier also contended that Claimant had exhausted all his administrative remedies by requesting the initial IRO in December 2008 and the subsequent CCH and had cut off his right to further appeals by undergoing the decompression procedure.

Claimant contended that once medical treatment had been provided, he was entitled to the same opportunity for a retrospective review about its necessity that would be available for a treatment that did not require preauthorization. Specifically, Claimant asserted that he was entitled to a retrospective necessity review by an IRO, so has not exhausted his administrative remedies. He stated that potential new necessity issues, such as whether the treatment was administered as the result of an emergency, were subject to review. He stated that although Rule 133.308 does not speak directly to the issue of a second IRO review, neither does it prohibit a second review in appropriate

---

[6] 22 TEX. ADMIN. CODE § 133.308(j).

[7] Claimant Ex. 6, p. 2 (February 10, 2009) (in pertinent part):

[Interrogatory] 12. Please provide the date you elected to undergo the L5-S1 plasma decompression as well as the contact information for the physician who performed the procedure.

ANSWER:
My condition worsened to the point that I was not able to function at all. I was under a lot of pain and spasms and no longer able to stand the pain and discomfort even with the medication I had taken. My doctor and I agreed that I had no choice but to undergo the L5-S1 Plasma Disc Decompression on 1/29/2009.

circumstances. He asserted that the question of whether Claimant's condition merited emergency treatment was such a circumstance.

C. Applicable Law

The Workers' Compensation Act (the Act) provides that certain procedures require preauthorization before a carrier will be obligated to pay for those procedures.[8] Among those procedures are non-emergency spinal surgery and inpatient hospitalization, for any procedure and any length of stay. The Act states that an insurance carrier is not responsible for treatments and services requiring preauthorization unless preauthorization is sought and obtained from either the insurance carrier or ordered by the Division.[9]

However, an exception is made for spinal surgery that is conducted in a medical emergency.[10] The Division's rules define an emergency.[11]

> (3) Emergency—Either a medical or mental health emergency as follows:
>
> > (A) medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
> >
> > > (i) placing the patient's health or bodily functions in serious jeopardy, or
> >
> > > (ii) serious dysfunction of any body organ or part;
> >
> > (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

An IRO reviews medical necessity questions.[12] Claimants may request an IRO for

---

[8] TEX. LAB. CODE ANN. § 413.014(c).
[9] TEX. LAB. CODE ANN. § 413.014(d). This provision references the Commission, the predecessor to the Division.
[10] TEX. LAB. CODE ANN. § 408.26.
[11] 28 TEX. ADMIN. CODE § 133.2(3).
[12] 28 TEX. ADMIN. CODE § 133.308.

preauthorization issues, concurrent medical dispute resolution, and also for retrospective medical dispute resolution.[13] However, the Division need not automatically grant an IRO. The Division may deny a request for a variety of reasons including a non-compliant submission, a request from an improper party, or resolution of the dispute.[14] In this case, the Division's representative did not cite one of the reasons in the rule for denial. However, the text of the decision is consistent with a reading that the Division denied Claimant's request for an IRO on the basis that the matter had previously been resolved by the initial IRO.[15] Previous resolution of the dispute is one of the grounds for dismissal.[16]

A claimant whose request for an IRO review of a retrospective medical necessity dispute is entitled to a review of the decision to deny, either at the Division or, for disputes involving an amount of $3,000 or more, through a contested case hearing at SOAH. That is, the Division's denial is treated as if it were a dismissal of the dispute for providing an appellate forum.[17] The rule provides a more limited appeal route for a prospective medical necessity dispute. Rule 133.308 provides that an aggrieved party may request a Division CCH conducted by a Division hearing officer.[18] The decision by the Division's hearing officer is appealable to district court.[19]

D. Analysis

The difference between the parties on the appropriate legal approach to this issue lies in the differing way in which the parties characterize the request for a second IRO. Carrier sees the dispute as a continuation of the dispute regarding the medical necessity for the procedure that reaches back to the Carrier's initial denial of the procedure in October 2008. In the Carrier's view, that dispute

---

[13] 28 TEX. ADMIN. CODE § 133.308(g)
[14] 28 TEX. ADMIN. CODE § 133.308(j).
[15] The denial letter states as follows:

> Retrospective review of medical necessity is not applicable in this case because the surgery required preauthorization. The intent of medical necessity retrospective review is for the denial of those services that have not been afforded an opportunity for review by an IRO. Carrier Ex. A.

[16] 28 TEX. ADMIN. CODE § 133.308(j)(4).
[17] 28 TEX. ADMIN. CODE § 133.308(t).
[18] 28 TEX. ADMIN. CODE § 133.308(t)(1)(B).
[19] 28 TEX. ADMIN. CODE § 133.308(v).

ended once Claimant underwent the decompression procedure in January 2009. Therefore, further proceedings are unwarranted. The Division's denial of the second IRO request agrees with that view.

Claimant's position is that administration of the decompression procedure did not, per se, close off the possibility for any review of the necessity for the procedure. Rather, it changed the question to be reviewed. That is, the retrospective necessity review would be limited to the question of whether the procedure was performed in response to a medical emergency, pursuant to Sec. 408.26 of the Act. In Claimant's view, he is not asking for a continuation of a prior review, but for a new review based on what he contends were circumstances that changed between October 2008 and the end of January 2009.

Claimant states accurately that Rule 133.308 does not bar two IRO reviews. However, the language of the rule itself provides some guidance that the IRO process is not intended to be iterative. Specifically, the Division may dismiss claims previously resolved and was also granted latitude to dismiss claims for other good cause. The dismissal by the CCH hearing officer of Claimant's case in March 2009, while not definitive agency policy, nevertheless reflects the agency's practices in regard to drawing the line between prospective and retrospective reviews.

In addition, the rule cannot be read in a vacuum, but must be considered within the statutory framework. As Carrier has argued, the Act clearly provides that a carrier is not obligated to pay for treatment requiring preauthorization that has not been preauthorized.

Claimant's assertion that a second, different claim arose is not born out by the procedural history of this case, although it is not without some support due to the time periods involved. Three months elapsed between the first time Claimant asked for preauthorization and the date on which the decompression procedure occurred. That is a sufficient length of time for significant changes to occur in a person's medical condition, and Claimant's answers to discovery, apparently made in February 2009, suggest that changes may have occurred. Nevertheless, as the prospective medical necessity issue was still under consideration by a CCH hearing officer on the date on which Claimant

underwent the decompression procedure, Claimant put himself at substantial financial risk of not being compensated because the CCH hearing officer could still rule against him.

Furthermore, Claimant apparently failed to raise the issue of potential emergency in either the MDR proceeding, which concluded in mid-2009, or in its request for an IRO at the end of December 2009. Emergency treatment being the only exception to the preauthorization requirement for spinal surgery, it is not at all clear why Claimant did not raise the emergency issue in the clearest possible terms at every turn.[20]

Claimant's assertions must be measured against the long-standing authority regarding preauthorization of spinal surgeries. The Act makes it clear that the Carrier does not incur liability until those procedures are preauthorized. This statute has been in place for a number of years and there are many contested case decisions on record in which carriers have been barred from raising medical necessity once they have given preauthorization for a treatment or procedure. This law cannot be applied selectively against carriers, but not in their favor.

Claimant also raises the valid concern that a ruling denying him an IRO would be tantamount to saying that no intervening emergency procedure could be considered after a preauthorization denial. Claimant's concern, while valid, is somewhat overstated. That decision does not hold that there could never be circumstances in which an emergency could occur after a denial of preauthorization that might require the same or similar treatment as that previously denied. The decision only addresses the exercise by the Division of its discretion under the facts known to them at the time they denied Claimant's request. The only indication of an intervening emergency condition that appears in the lengthy history of this dispute is Claimant's self-reported decline in his condition over an unknown period, which appeared in an answer by Claimant to discovery from the Carrier.[21] Given that, the Division's conclusion that Claimant's IRO request in December 2009

---

[20] Claimant did not submit a position summary to the MDR, but only stated that his claim was "not paid by the insurance company." Claimant Ex. 4, p. 1.

[21] It is unknown whether Division staff members reviewing Claimant's December 2009 request had knowledge of prior discovery. In order to consider the Division's action in the light most favorable to Claimant, the ALJ evaluated whether the staff member's response followed requirements of the rule, had he known this information.

involved the same treatment, for the same purpose that had been reviewed prospectively in December 2008, was not erroneous.

In sum, the ALJ concludes that Carrier was entitled to a decision as a matter of law because the Division acted consistently with Rule 133.308 and the Act in concluding Claimant had exhausted his administrative remedies in regard to medical necessity. There is no legal basis to require the Division to grant Claimant's request for a retrospective IRO review.

III. FINDINGS OF FACT

1. On , Claimant suffered a compensable workplace injury to his low back.

2. In October 2008, Claimant twice requested preauthorization from TPS Joint Self Insurance Fund (Carrier) for a plasma disc decompression at the L5-S1 level of the spine (the decompression procedure) to treat Claimant's injury.

3. The decompression procedure is a spinal surgery for which preauthorization is required if not performed on an emergency basis.

4. Carrier did not preauthorize the decompression procedure.

5. In December 2008, the Texas Department of Insurance, Division of Workers' Compensation (TDI/Division), appointed an independent review organization (IRO), Core 400 LLC, to conduct a prospective review of the medical necessity of the decompression procedure.

6. On December 23, 2008, in IRO Decision No. 17303, the IRO concluded that the decompression procedure was not medically necessary to treat Claimant's injury (the initial IRO decision).

7. Claimant timely filed an appeal of the initial IRO decision with the Division; the appeal was assigned to the Division Field Office in Laredo, Texas, to conduct a contested case hearing (CCH).

8. On January 30, 2009, Claimant underwent the decompression procedure.

9. Claimant paid out-of-pocket for the decompression procedure.

10. Claimant paid $6,609.90 for the decompression procedure, which included costs for pathology laboratory services, X-rays, anesthesia, orthopedic services, prescription medication, and a hospital bill.

11. Claimant requested reimbursement from Carrier for all out-of-pocket payments he made.

12. Carrier declined to reimburse Claimant for his out-of-pocket payments for the decompression procedure on the basis it had not been preauthorized.

13. On March 4, 2009, Hearing Officer Carole Faugerat dismissed Claimant's appeal of the initial IRO decision based on Carrier's plea to the jurisdiction. Carrier contended that the disputed procedure, having been performed, was a retrospective medical necessity dispute concerning a claim in excess of $3,000, which could only be heard by the State Office of Administrative Hearings (SOAH).

14. Claimant then pursued his claim for reimbursement though the medical fee dispute resolution (MDR) process.

15. On June 24, 2009, the MDR hearing officer denied reimbursement for Claimant's out-of-pocket payments for the decompression procedure.

16. Claimant filed a request for a contested case hearing at SOAH, and the case was referred for hearing (the initial contested case).

17. Claimant withdrew his request for a contested case on the basis the MDR procedure did not apply to a medical necessity decision, and the initial contested case was dismissed on August 7, 2009, without prejudice.

18. On December 14, 2009, Claimant sought a retrospective IRO review of the medical necessity of the decompression procedure based on Carrier's denial of reimbursement for Claimant's out-of-pocket expenses.

19. The December 14, 2009, request did not raise the issue that the decompression procedure had been performed on an emergency basis.

20. On December 30, 2009, the Division, in a letter from Thomas Morgan, Director of the Health and WC Network Division of TDI, denied Claimant's request for a second IRO review.

21. Claimant's request was denied on the basis that the issue of medical necessity had already been resolved in the preauthorization review process and that Claimant was not entitled to a retrospective IRO review after the procedure had been performed without preauthorization.

22. Claimant requested a contested case hearing at SOAH and the case was referred for hearing (the second contested case).

23. On January 1, 2010, the Division issued notice of the second contested case to the parties.

24. The notice of hearing was sent to Claimant at :
and to Carrier in care of Timothy White at

25. On January 29, 2010, Carrier filed a motion for summary disposition, and later, a response.

26. On February 29, 2010, Claimant filed a reply, and later, a response.

27. On March 12, 2010, the presiding Administrative Law Judge, Cassandra J. Church, ruled that the matter could be disposed on the basis of the pleadings filed in connection with the summary disposition motion and canceled the scheduled hearing on the merits.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order with proposed findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ANN. ch. 2003, TEX. LAB. CODE ANN. § 413.031, and 28 TEX. ADMIN. CODE § 133.308(t).

2. SOAH has jurisdiction to summarily dispose of a matter without an evidentiary hearing and to issue a decision in cases referred by the Division pursuant to TEX. GOV'T CODE ANN. ch. 2003 and 1 TEX. ADMIN. CODE § 155.505 if: (1) the evidence supporting the motion for summary disposition shows that there no genuine issue as to any material fact, and (2) a party is entitled to a decision in its favor as a matter of law.

3. The parties received proper and timely notice of the hearing pursuant to TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. The decompression procedure was a spinal surgery for which preauthorization by the responsible carrier or the Division was required in order to trigger Carrier's obligation to pay for the procedure, pursuant to TEX. LAB. CODE ANN. § 413.014(c).

5. Claimant exhausted all administrative remedies available to challenge Carrier's denial of preauthorization for the decompression procedure, as provided in 28 TEX. ADMIN. CODE § 133.308.

6. The Division's decision to decline to assign an IRO to conduct a retrospective review of medical necessity for the decompression procedure was based on a valid reason, as provided by 28 TEX. ADMIN. CODE § 133.308(j).

ORDER

IT IS THERFORE ORDERED that TPS Joint Self Insurance Fund's Motion for Summary Disposition is granted.

IT IS FURTHER ORDERED that the Division is not required to a grant Claimant's request for a retrospective IRO review in regard to the medical necessity for the decompression procedure that Claimant underwent on January 30, 2009.

SIGNED May 11, 2010.

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