APPEAL NO. 100379-s
FILED MAY 28, 2010

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on March 10, 2010.[1] Regarding the sole disputed issue, the hearing officer determined that the preponderance of the evidence is contrary to the Independent Review Organization's (IRO) decision. The appellant (self-insured) appealed the hearing officer's IRO decision. Additionally, the self-insured asserts that the hearing officer abused her discretion in admitting the respondent's (claimant) evidence which was not timely exchanged. The self-insured states that the hearing officer's evidentiary ruling resulted in an improper judgment. The claimant responded, urging affirmance.

DECISION

Reversed and rendered.

EVIDENTIARY RULING/
DISCOVERY IN AN EXPEDITED CCH

To obtain a reversal of a judgment based upon the hearing officer's abuse of discretion in the admission or exclusion of evidence, an appellant must first show that the admission or exclusion was in fact an abuse of discretion, and also that the error was reasonably calculated to cause and probably did cause the rendition of an improper judgment. Hernandez v. Hernandez, 611 S.W.2d 732 (Tex. Civ. App.-San Antonio 1981, no writ). In determining whether there has been an abuse of discretion, the Appeals Panel looks to see whether the hearing officer acted without reference to any guiding rules or principles. Appeals Panel Decision (APD) 043000, decided January 12, 2005; Morrow v. H.E.B., Inc., 714 S.W.2d 297 (Tex. 1986).

This is a spinal surgery case and an expedited CCH was set for September 28, 2009. *See* Section 413.031(l) and 28 TEX. ADMIN. CODE § 133.308(u) (Rule 133.308(u)). Rule 142.13(g) provides that the notice setting an expedited hearing, or a hearing held without a prior benefit review conference (BRC), shall include time limits for completion of discovery. The preamble to Rule 142.13 states that this rule was amended to add a new subsection (g), which provides that the notice setting an expedited hearing, or hearing held without a prior BRC, shall include time limits for conducting prehearing discovery, and that the amendment is necessary to inform parties of this exception to the usual time limits for prehearing discovery set out in the 1989 Act. (17 Tex. Reg. 949, 1992). In APD 972286, decided December 22, 1997, the Appeals Panel stated under Rule 142.13(g), parties had until a certain date, "to exchange items that were intended to be offered into evidence." In evidence is an "Order Setting [CCH] on an [IRO]" dated September 9, 2009, which states the date, time

[1] The hearing officer incorrectly lists on the decision and order that the CCH was held on February 23, 2010, rather than March 10, 2010.

and location of the CCH, however, it does not state the time limits for completion of discovery, pursuant to Rule 142.13(g).

The hearing officer commented at the CCH that the claimant's failure to exchange documentation with the self-insured was attributed to the ombudsman[2] and the claimant's evidence is crucial to the determination of the issue in dispute, and she stated that for those reasons the claimant showed good cause for the untimely exchange of documentation. The hearing officer's reasoning is not good cause for the claimant's untimely exchange. However, because the order setting an expedited CCH did not include time limits for completion of discovery, the hearing officer's admission of the claimant's evidence was not reversible error.

THE IRO DECISION

Section 408.021 provides that 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. Section 401.011(22-a) defines "[h]ealth care reasonably required" as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with: (A) evidence-based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Section 401.011(18-a) defines "[e]vidence-based medicine" as the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients. Rule 133.308(t) provides that in a CCH, the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence.

The parties stipulated that: (1) the claimant sustained a compensable lumbar spine injury on _____, and (2) the IRO decision determined that the claimant should not have spinal surgery as recommended. The IRO decision dated August 20, 2009, upheld the self-insured's denial of the requested surgical procedure which was a "[r]evision lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of a bone growth stimulator at L3, L4, and L5" with inpatient length of stay (LOS) for two days. The screening criteria or other clinical basis used by the IRO to make the decision was identified as: (1) medical judgment, clinical experience and expertise in accordance with accepted medical standards; (2) Milliman Care Guidelines; and (3) the Official Disability Guidelines-Treatment in Workers' Comp published by Work Loss Data Institute (ODG) for spinal discectomy/laminectomy and spinal fusion. The IRO decision attached a portion of the ODG for spinal fusion entitled

[2] The Appeals Panel has held that an ombudsman cannot stand in the shoes of the claimant and is not the equivalent of "the party;" an ombudsman may appropriately assist a claimant but is not a representative for a claimant. *See* APD 92025, decided March 16, 1992; APD 94358, decided May 11, 1994.

"Pre-Operative Surgical Indications Recommended" which provides that pre-operative clinical surgical indications for spinal fusion should include all of the following:

> (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed[; &] (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

The IRO decision stated that based on the information reviewed the requested "revision fusion with fusion of two above levels" cannot be justified as medically necessary because: (1) "[t]wo previous practitioners have indicated that the claimant's prior L5-S1 fusion has healed;" (2) "[i]t is not clear from the records provided if the claimant has instability on dynamic flexion/extension views;" (3) "[t]hough a psychological evaluation was recommended at one point, records do not indicate that one has been performed;" and (4) "[t]he records are not clear what type of nonoperative conservative treatment has been rendered." Further, the IRO states that "[f]or all of these reasons, the surgical request does not currently meet appropriate ODG criteria for the requested surgery."

In the Background Information section of the decision, the hearing officer states that the "IRO reviewer correctly applied the criteria set out in the ODG for the requested spinal surgery procedures which are set out in the IRO decision in evidence." However, the hearing officer found that the claimant does meet the ODG criteria as a candidate for a revision lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of a bone growth stimulator at L3, L4 and L5 with inpatient LOS for two days as recommended by the claimant's treating surgeon. The hearing officer relied on (Dr. Z), the treating surgeon, medical report dated March 10, 2010, in which he references medical records that were not in existence at the time of the IRO decision, August 20, 2009.

In evidence is Dr. Z's medical report dated March 8, 2010, in which he disagrees with the IRO decision and responds to the screening criteria used by the IRO to make a decision. Dr. Z addresses the IRO statement regarding a psychological evaluation and he states that the claimant underwent a pre-surgery psychological evaluation on October 7, 2009. The hearing officer correctly points out in her decision that the claimant had the psychological evaluation after the IRO decision.

Rule 133.308(l) provides that the carrier or the carrier utilization review agents (URA) shall submit the documentation required in paragraphs (1)-(6) of this subsection to the IRO not later than the third working day after the date the carrier reviews the

notice of the IRO assignment.[3] Further, Rule 133.308(m) provides that the IRO shall request additional necessary information from either party or from other providers whose records are relevant to the review. In a public comment to Rules 133.308(l) and (m), the commenter states that denials need to be based on current medical records, and that it is the responsibility of the reviewing physician to make sure that he has been provided with such information when he performs the review. The Texas Department of Insurance, Division of Workers' Compensation's (Division) response states that it "agrees in part and disagrees in part . . . . The Division agrees that reviews need to be based on current medical records, but does not believe that changes to the rule are necessary to accomplish this" and references Rule 133.308(m). (*See* 33 Tex. Reg. 3985, 2008). Also, Rule 133.308(p)(1)(A-B) provides that the IRO decision must include: a list of all the medical records and other documents reviewed by the IRO, including the dates of those documents and, a description and the source of the screening criteria or other clinical basis used to make the IRO decision. (*See* Rule 133.308(p)(1)(A-F)).[4]

In the instant case, the pre-surgery psychological evaluation was performed on October 7, 2009, after the IRO decision. The IRO determined that the spinal surgery request did not currently meet appropriate ODG criteria for the requested surgery. Specifically, the IRO determined, in part, that the spinal surgery request did not include the following pre-operative clinical surgical indication: "[p]sychosocial screen with confounding issues addressed." At the time of the IRO decision on August 20, 2009, the medical records reviewed by the IRO did not meet the ODG criteria for spinal surgery.

The claimant failed to present evidence consistent with the requirement of Section 401.011(22-a) to establish that the preponderance of the evidence is contrary to the decision of the IRO dated August 20, 2009. We reverse the hearing officer's decision that the preponderance of the evidence is contrary to the decision of the IRO

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[3] Rule 133.308(l) provides that the documentation shall include: (1) the forms prescribed by the Department for requesting IRO review; (2) all medical records of the employee in the possession of the carrier or the URA that are relevant to the review, including any medical records used by the carrier or the URA in making the determinations to be reviewed by the IRO; (3) all documents, guidelines, policies, protocols and criteria used by the carrier or the URA in making the decision; (4) all documentation and written information submitted to the carrier in support of the appeal; (5) the written notification of the initial adverse determination and the written adverse determination of the reconsideration; and (6) any other information required by the Department related to a request from a carrier for the assignment of an IRO.

[4] Rule 133.308(p)(1)(A-F) provides that the IRO decision must include: (A) a list of all medical records and other documents reviewed by the IRO, including the dates of those documents; (B) a description and the source of the screening criteria or clinical basis used in making the decision; (C) an analysis of, and explanation for, the decision, including the findings and conclusions used to support the decision; (D) a description of the qualifications of each physician or other health care provider who reviewed the decision; (E) a statement that clearly states whether or not medical necessity exists for each of the health care services in dispute; (F) a certification by the IRO that the reviewing provider has no known conflicts of interest pursuant to the Insurance Code Chapter 4201, Labor Code § 413.032, and § 12.203 of this title.

and render a new decision that the preponderance of the evidence is not contrary to the decision of the IRO.

The true corporate name of the insurance carrier is **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

DR. JJ, SUPERINTENDENT
(ADDRESS)
(CITY), TEXAS (ZIP CODE).

_____
Veronica L. Ruberto
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Margaret L. Turner
Appeals Judge