SOAH DOCKET NO. 454-09-2789.M5
(MDR NO. M5-09-16841-01)

WELLNESS GROUP & PAIN CENTER, **Petitioner**	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
ARGONAUT SOUTHWEST INSURANCE COMPANY, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

The above-referenced proceeding was referred by Texas Department of Insurance, Division of Workers' Compensation (Division) to consider the retrospective medical necessity of health care exceeding $3,000. At the hearing on the merits held on May 18, 2009, Respondent, Argonaut Southwest Insurance Company (Argonaut), represented by attorney Jon Groves, re-urged its motion to dismiss for lack of jurisdiction originally filed in this case on March 11, 2009, and which was denied. At the hearing, Argonaut presented additional argument and legal citations and a copy of the Official Disability Guidelines (ODG).[1] Argonaut argues that the State Office of Administrative Hearings (SOAH) lacks jurisdiction over this matter because the issue is lack of preauthorization and not retrospective medical necessity.[2] In the alternative, Argonaut argues that reimbursement should be denied because the treatment provided was not preauthorized. Wellness Group and Pain Center (Wellness), represented by Randal Floyd, opposed the motion and requested a finding that the treatment provided was medically necessary. The administrative law judge (ALJ) denies reimbursement because the treatment was not preauthorized.

[1] *Official Disability Guidelines – Treatment in Workers' Comp*, published by the Work Loss Data Institute.

[2] Cases involving a denial of preauthorization go through the Independent Review Organization (IRO) process and are not appealable to SOAH, but are appealed in accordance with TEX. LABOR CODE ANN. (Code) chap. 410 and § 413.0311. Cases involving the retrospective medical necessity of health care exceeding $3,000 go through the IRO process and are appealable to SOAH. TEX. LABOR CODE ANN. § 413.031(k). The Code is not clear about the appeal route for cases involving treatment that may have required preauthorization and preauthorization was denied, but the treatment was nevertheless provided and billed for.

I. BACKGROUND

Claimant, ., suffered a compensable injury on . Wellness provided eight days of "outpatient medical rehabilitation" services to Claimant from November 10 through 21, 2008, billing a total of $4,600. Wellness first sought preauthorization to provide 20 sessions of outpatient medical rehabilitation treatment to Claimant on August 28, 2008. Argonaut Ex. 3. Argonaut denied preauthorization on September 2, 2008, based upon its conclusion that Claimant had had limited success with previous work hardening treatment. Wellness sent a request for reconsideration on October 5, 2008, which was denied on October 10, 2008. Argonaut Ex. 4.

On October 28, 2008, Wellness sought review of the denial before an IRO. Argonaut Ex. 11. An IRO decision dated November 18, 2008,[3] denied the request for preauthorization. Wellness filed a request for a medical contested case hearing on November 21, 2008. On December 16, 2008, the Dallas Field Office of the Division issued an order setting a prehearing conference on December 29, 2008, to consider the issue of prospective medical necessity. Argonaut Ex. 8. The outcome of the prehearing conference was not presented to the ALJ. Argonaut stated in its motion to dismiss that the matter was continued because the services had already been provided. Wellness asserted in its response to the motion filed on March 30, 2009, that Argonaut raised the point that the hearing officer lacked jurisdiction because the case was now one of retrospective medical necessity. On February 23, 2009, Wellness submitted an appeal of the IRO decision and requested a hearing on the issue of the retrospective medical necessity of health care exceeding $3,000.

II. DISCUSSION

The Commissioner of Insurance (Commissioner) is required to specify by rule which health care treatments and services require express preauthorization or concurrent review by an

[3] There is a discrepancy in the date. The first page of the cover letter of the decision refers to the decision being made on 11/09/2008, whereas the first page of the decision refers to the date of review as 11-18-08.

insurance carrier.[4] An insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the Commissioner.[5]

The Commissioner adopted the ODG as the treatment guidelines for health care provided after May 1, 2007.[6] The same rule also provides that an insurance carrier is not liable for the costs of treatments or services provided in excess of the treatment guidelines unless the treatments were provided in an emergency or were preauthorized in accordance with § 134.600 (the preauthorization rule).[7] According to that rule, non-emergency health care requiring preauthorization includes "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."[8]

As the IRO noted at page 8 of its decision, the ODG does not reference "outpatient medical rehabilitation" (CPT code 97799-MR). Argonaut Ex. 1 at 8. Therefore, the IRO considered the request under "interdisciplinary rehabilitation programs" in the ODG, which refers readers to the guidelines for chronic pain management programs. *See* Argonaut Ex. 2. Relying on those guidelines, the IRO found that Claimant did not meet the entrance requirement that the worker "be no more than 2 years past date of injury." Argonaut Ex. 1 at 9 quoting the ODG.

In response to Argonaut's motion to dismiss, Wellness first argued that because Code § 413.014(c)(1-6) does not list outpatient medical rehabilitation as a medical treatment requiring preauthorization, preauthorization is not required. Wellness' position overlooks the wording of

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[4] Code § 413.014(b).

[5] Code § 413.014(d).

[6] 28 TEX. ADMIN. CODE (TAC) § 137.100(a).

[7] 28 TAC § 137.100(d).

[8] 28 TAC § 134.600(p)(12).

subsection (c), which states that the commissioner's rules adopted under the section must provide that preauthorization is required *at a minimum* for the six listed treatments and services including physical and occupational therapy.[9] (Emphasis added.)

Wellness also argued that it was not appropriate for its program to be reviewed under the ODG guidelines for chronic pain management. Wellness argued that the TDI-DWC CARF[10] standards, which it attached to its response as Ex. IRO-3, applied instead. Nevertheless, CARF's guidelines have limited application. Only work hardening or work conditioning provided by a CARF-accredited facility is exempt from preauthorization.[11] Therefore, even though outpatient medical rehabilitation is not specifically listed in 28 TAC § 134.600(p) as requiring preauthorization, because it exceeds or is not addressed by the Commissioner's adopted guidelines, it must be preauthorized.[12]

Admittedly, the Division's rules concerning the newly adopted ODG are untested and potentially subject to differing interpretations. Sections 134.600 and 137.100, read together, strongly suggest, however, that nonemergency treatment falls into three broad categories: (1) treatments that are outside the ODG and therefore must always be preauthorized; (2) treatments specified in § 134.600 that require preauthorization regardless of what the ODG says; and (3) treatments that are within the ODG and not listed in § 134.600, and therefore do not require preauthorization. Because outpatient medical rehabilitation is not specifically addressed in the ODG, or in the alternative, was sought more than two years after the injury occurred, it is outside the applicable treatment guidelines. As a result, the treatment falls into the first category, and preauthorization was required.

Because Wellness provided the treatment without preauthorization, the ALJ denies Wellness' request for reimbursement of the services provided.

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[9] Code § 413.014(c)(4).

[10] Commission of Accreditation of Rehabilitation Facilities.

[11] 28 TAC § 134.600 (a)(4) and (p)(4), (7).

[12] 28 TAC § 134.600(p)(12).

III. FINDINGS OF FACT

1. Claimant , suffered a compensable injury on

2. On August 28, 2008, Wellness Group and Pain Center (Wellness) sought preauthorization from Argonaut Southwest Insurance Company to provide 20 sessions of "outpatient medical rehabilitation treatment" to Claimant.

3. Argonaut Southwest Insurance Company denied preauthorization on September 2, 2008, based upon its conclusion that Claimant had had limited success with previous work hardening treatment.

4. Wellness sent a request for reconsideration on October 5, 2008, which Argonaut denied on October 10, 2008.

5. On October 28, 2008, Wellness sought review of the denial before an Independent Review Organization (IRO).

6. The Texas Department of Insurance (Department), Health & WC Network Certification and Quality Assurance referred the matter to an IRO.

7. The IRO denied the request for preauthorization in a decision dated November 18, 2008.

8. Looking to the *Official Disability Guidelines – Treatment in Workers Comp* (ODG), published by the Work Loss Data Institute, which does not reference "outpatient medical rehabilitation" (CPT code 97799-MR), the IRO considered the request under "interdisciplinary rehabilitation programs" in the ODG, which refers readers to the guidelines for chronic pain management programs. Based on those guidelines, the IRO found that Claimant did not meet the entrance requirement that the worker "be no more than 2 years past date of injury."

9. Wellness provided eight days of outpatient medical rehabilitation services to Claimant from November 10 through 21, 2008, billing a total of $4,600.

10. Wellness filed a request for a medical contested case hearing on November 21, 2008. On , the Dallas Field Office of the Department's Division of Workers' Compensation issued an order in Docket No. , IRO Case No. , setting a prehearing conference or , to consider the issue of prospective medical necessity.

11. The hearing officer continued the matter because the services had already been provided.

12. On February 23, 2009, Wellness submitted an appeal of the IRO decision to the Division and requested a hearing on the issue of the retrospective medical necessity of health care exceeding $3,000.

13. The Division issued a notice of hearing on February 25, 2008, setting the hearing at the State Office of Administrative Hearings (SOAH).

14. All parties received not less than 10 days' notice of the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over matters related to a hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. (Code) § 413.031 and TEX. GOV'T. CODE ANN. ch. 2003.

2. Notice of the hearing was proper and timely. TEX. GOV'T. CODE ANN. §§ 2001.051 and 2001.052.

3. Section 413.014(b) of the Code requires the Commissioner of Insurance (Commissioner) to specify by rule which health care treatments and services require express preauthorization or concurrent review by an insurance carrier.

4. Section 413.014(d) of the Code states that an insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the Commissioner.

5. The Commissioner adopted the ODG as the treatment guidelines for health care provided after May 1, 2007. 28 TEX. ADMIN. CODE (TAC) § 137.100(a).

6. Non-emergency health care requiring preauthorization includes "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier. 28 TAC § 134.600(p)(12).

7. An insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless the treatment(s) or service(s) were provided in a medical emergency or the treatment(s) or service(s) were preauthorized in accordance with § 134.600. 28 TAC § 137.100(d).

8. Because outpatient medical rehabilitation is not specifically addressed in the ODG, or in the alternative, was sought more than two years after the injury occurred, it is outside the applicable treatment guidelines, and therefore preauthorization was required.

9. Because Wellness provided the treatment without preauthorization, Wellness' request for reimbursement is denied.

ORDER

IT IS ORDERED that Argonaut Southwest Insurance Company is not required to reimburse Wellness Group & Pain Center for the services in dispute in this case.

SIGNED June 15, 2009.

Katherine L. Smith

KATHERINE L. SMITH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS