SOAH DOCKET NOS. 454-22-0039.M4-NP, 454-22-0040.M4-NP, 454-22-0043.M4-NP, 454-22-0044.M4-NP, 454-22-0045.M4-NP

STATE OFFICE OF RISK MANAGEMENT,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
ANGLETON REHABILITATION AND WELLNESS,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

The State Office of Risk Management (SORM) challenges the decisions of the Texas Department of Insurance, Division of Workers' Compensation (Division) to award additional reimbursement to Angleton Rehabilitation and Wellness (Angleton) for physical therapy services provided for an injured worker in April-July 2020. SORM preauthorized the physical therapy sessions, but denied payment to Angleton for the portion of the sessions that exceeded one hour. The Administrative Law Judge (ALJ) concludes that SORM was not authorized to condition its approval on a time limitation that Angleton did not agree to. Therefore, the ALJ affirms the Division's Medical Fee Dispute (MFD) Decisions, and orders SORM to reimburse Angleton $2,880.70 for the services at issue in this proceeding.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no disputed issues regarding notice or jurisdiction in this proceeding. Therefore, those matters are addressed in the findings of fact and conclusions of law without further discussion here.

After SORM made reduced payments on Angleton's claims for reimbursement for the services in question, Angleton filed requests for medical fee dispute resolution with the Division. This Decision and Order addresses the following MFD Decisions issued by the Division:

1) August 27, 2020 MFD Decision, ordering SORM to pay $1,369.58 in additional reimbursement to Angleton for physical therapy services provided from February 27-March 31, 2020.[1]

2) September 25, 2020 MFD Decision, ordering SORM to pay $531.31 in additional reimbursement to Angleton for physical therapy services provided from April 1-23, 2020.[2]

3) October 15, 2020 MFD Decision, ordering SORM to pay $348.86 in additional reimbursement to Angleton for physical therapy services provided from May 6-21, 2020.[3]

4) November 19, 2020 MFD Decision, ordering SORM to pay $241.22 in additional reimbursement to Angleton for physical therapy services provided from May 27-June 3, 2020.[4]

5) January 29, 2021 MFD Decision, ordering SORM to pay $389.73 in additional reimbursement to Angleton for physical therapy services provided from July 8-22, 2020.[5]

Angleton requested a hearing at the State Office of Administrative Hearings (SOAH) to contest each of the MFD Decisions. On September 8, 2021, the Division issued a Notice of Hearing in each case. Subsequently, these cases were joined into a single proceeding for all purposes other than appeal and scheduled for a hearing on the merits.[6]

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[1] SORM Ex. 14. The appeal from the August 27, 2020 MFD Decision was docketed at SOAH at Case No. 454-22-0043.M4-NP.

[2] SORM Ex. 24. The appeal from the September 25, 2020 MFD Decision was docketed at SOAH as Case No. 454-22-0044.M4-NP.

[3] SORM Ex. 32. The appeal from the October 15, 2020 MFD Decision was docketed at SOAH at Case No. 454-22-0040.M4-NP.

[4] SORM Ex. 41. The appeal from the November 19, 2020 MFD Decision was docketed at SOAH at Case No. 454-22-0045.M4-NP.

[5] SORM Ex. 51. The appeal from the January 29, 2021 MFD Decision was docketed at SOAH at Case No. 454-22-0039.M4-NP.

[6] Order No. 2, issued October 15, 2021.

On January 25, 2022, ALJ Sarah Starnes convened a hearing on the merits via the Zoom government videoconferencing platform before SOAH in Austin, Texas. SORM appeared through attorney Deea Western. Angleton appeared through its non-attorney representative, Keith Pesnell. The record closed at the conclusion of the hearing on that same date.

II. DISCUSSION

A. Applicable Law

A healthcare provider must request preauthorization from an injured worker's insurance carrier prior to providing physical therapy to the worker.[7] The insurance carrier is not liable for treatments or services requiring preauthorization unless preauthorization was sought and obtained from the insurance carrier or has been ordered by the Commissioner of Worker's Compensation.[8]

A request for preauthorization must include, among other things, the specific health care requested, the number of specific treatments and the period of time to complete the treatments, information to support the medical necessity of the requested treatments, and the estimated date of the proposed health care.[9] When an insurance carrier approves a preauthorization request, the approval must include the specific health care, the approved number of treatments and specific period of time to complete the treatments, and notice of any unresolved dispute regarding the denial of compensability or liability.[10] Further, the insurance carrier "shall not condition an approval or change any elements of the request . . . unless the condition or change is mutually agreed to by the health care provider and insurance carrier and is documented."[11] Once a treatment has been preauthorized, the treatment or service is not subject to retrospective review for medical necessity.[12]

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[7] Tex. Labor Code § 413.014(c)(4); 28 Tex. Admin. Code § 134.600(f), (p)(5).

[8] Tex. Labor Code §§ 401.011(8), 413.014(c).

[9] 28 Tex. Admin. Code § 134.600(f)(2)-(4), (9).

[10] 28 Tex. Admin. Code § 134.600(l).

[11] 28 Tex. Admin. Code § 134.600(n).

[12] Tex. Labor Code § 413.014(e).

The Texas Department of Insurance has adopted the Official Disability Guidelines (ODGs) for workers' compensation medical treatment in Texas.[13] Treatment provided in accordance with the ODGs is presumed reasonable and, absent an emergency, the insurance carrier is typically not liable for the costs of treatments or services that exceed those guidelines if they were not preauthorized.[14] Relevant to physical therapy, the ODGs provide:

> Generally, there should be no more than 4 modalities/procedural units in total per visit, allowing the PT visit to focus on treatments that have shown evidence of functional improvement and limiting the total length of the visit to 45-60 minutes, unless additional circumstances require an extended length of treatment. Treatment times per session may vary based upon the patient's medical presentation but typically may be 45-60 minutes to provide full, optimal care to the patient. Additional time may be required for the more complex and slow-to-respond patients. While an average of 3 or 4 modalities/procedural units per visit reflect a typical visit, this is not intended to limit or cap the number of units that are medically necessary for a patient (for example, in unusual cases where co-morbidities involve completely separate body domains), but documentation should support any average that exceeds 4 units per visit. These additional units should be reviewed for medical necessity and then authorized if determined to be medically appropriate for the individual injured worker.[15]

If a health care provider is denied or paid a reduced amount for the medical service rendered, the provider is entitled to review by the Division.[16] If a dispute remains after that review, a party may request a contested case hearing at SOAH.[17] As the party requesting a hearing at

[13] 28 Tex. Admin. Code § 137.100.

[14] 28 Tex. Admin. Code § 137.100(c)-(d).

[15] Ex. 5 at SORM-000012-13.

[16] Tex. Labor Code § 413.031(a).

[17] Tex. Labor Code § 413.0312(e).

SOAH to challenge adverse MFD Decisions, SORM has the burden of proof to show by a preponderance of the evidence that Angleton is not entitled to additional reimbursement.[18] The hearing before SOAH is a de novo review of the issues involved.[19]

B. Evidence

At the hearing, SORM had 55 exhibits admitted into evidence and presented testimony from two witnesses: Jennifer Cooper, a utilization review manager with CareWorks, a company contracted to perform workers' compensation medical bill reviews for SORM; and Janine Lyckman, the cost-containment director for SORM. Mr. Pesnell testified on behalf of Angleton, and Angleton did not offer any additional exhibits. The underlying facts are not in dispute.

In February 2020, a physician ordered physical therapy "2-3 days per week for 4 weeks" to treat an injured worker's left arm and shoulder.[20] Angleton requested preauthorization and CareWorks reviewed the claim and approved the services or treatment, agreeing that they were medically necessary or appropriate. The preauthorization letter specified that what was approved was "physical therapy left upper extremity 2-3x4 (12 visits)," and that the services were approved from February 26-May 31, 2020.[21] The letter went on to state, "Per CMS Guidelines,[22] treatment past 45-60 minutes requires documentation substantiating the medical necessity of the additional time."[23]

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[18] 28 Tex. Admin. Code § 148.14(b), (e).

[19] See Vista Med. Ctr. Hosp. v. Texas Mut. Ins. Co., 416 S.W.3d 11, 17-18 (Tex. App.—Austin 2013, no pet.).

[20] Ex. 1.

[21] Ex. 2. SORM witness Jennifer Cooper testified that the letter's abbreviations meant that two or three visits per week were approved for a period of four weeks, for a total of up to twelve preapproved visits.

[22] CMS is an abbreviation of Centers for Medicare and Medicaid Services. See 28 Tex. Admin. Code § 134.203(a)(5). Ms. Cooper testified that CMS guidelines are a "preface to" or equal to ODG guidelines.

[23] Ex. 2 at 003.

In March 2020, Angleton submitted a preauthorization request for an additional 12 sessionsof physical therapy, which CareWorks also approved from March 27-June 27, 2020.[24] Another12 sessions were requested and approved in April 2020 (approved from April 29-July 15, 2020),[25]then 14 more sessions were requested and approved in June 2020 (approved from July 2, 2020-January 31, 2021).[26] Each of the preauthorization requests specified the number of sessions proposed and the procedure codes (CPT codes) for the treatments, referencing between five and ten CPT codes per request, but none of the requests specified the length of time to complete the treatments at each session. Each approval letter set a date range for the approved services and included the caveat that treatment past 45-60 minutes required documentation substantiating the medical necessity for more time.

Angleton provided physical therapy to the injured worker at a number of visits beginning February 27, 2020. On the health insurance claim forms seeking reimbursement, services are billedin 15-minute increments, or units. Angleton submitted its bills to SORM and requested payment for four or more units per each session.[27] Angleton did not seek preauthorization for any of the sessions to exceed 60 minutes and disputes that it was required to do so.

Mr. Pesnell is a physical therapist and supervised the sessions at issue in this case. He testified that Angleton complied with the frequency and number of sessions that were preauthorized by SORM and that the services were provided within the time periods specified in the preauthorization letters. Mr. Pesnell denied that Angleton provided any treatments or servicesthat were not preauthorized. He admitted that many of the sessions exceeded 45-60 minutes but disputed that the preauthorization letters put any cap on the treatment time allowed per session.

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[24] Exs. 3-4.

[25] Exs. 18-19.

[26] Exs. 45-46.

[27] Exs. 10, 20, 28, 37, and 47.

Mr. Pesnell testified that he continued having sessions that exceeded 60 minutes despite learning from Angleton's benefits coordinator that SORM was reducing or denying bills for exceeding preauthorization. Mr. Pesnell explained that Angleton was ethically bound to treat the patient and help the patient improve and that the longer sessions were medically necessary in view of the patient's condition and history. He also asserted that the documentation submitted with the preauthorization requests was sufficient to support the level and duration of service he provided.

In reliance on its position that it only preauthorized 45-60 minutes per session, SORM approved reimbursement for only four units per visit and denied payment for other/additional units on the grounds that those charges had not been preauthorized and/or exceeded the preauthorization.[28] Angleton appealed to the Division. At issue in this case are Angleton's bills for thirteen visits between February 27 and March 31, 2020[29]; thirteen visits between April 1-23, 2020[30]; six visits between May 6-21, 2020[31]; four visits between May 27 and June 3, 2020[32]; and ten visits between July 8-22, 2020.[33]

The MFD Decisions found that Angleton was entitled to additional reimbursement for the disputed visits and that SORM's preauthorization letters did not limit reimbursement to four units/one hour per visit. Specifically, the MFD Decisions each state that the Division "finds the preauthorization reports are not in accordance with [28 Texas Administrative Code §] 134.600 because they don't list the 'number of specific health care treatments and the specific period of time requested to complete the treatments.'"[34] The MFD Decision also held that SORM's reliance on CMS was inapt because the Division's rules take precedence over any conflicting provision in the Medicare program.[35] SORM appealed those decisions to SOAH.

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[28] Ms. Lyckman testified that SORM approved the highest-paying CPT codes submitted for each visit, but approved no more than four units per visit.

[29] Ex. 10. These are the charges at issue in SOAH Docket No. 454-22-0043.M4-NP.

[30] Ex. 20. These are the charges at issue in SOAH Docket No. 454-22-0044.M4-NP.

[31] Ex. 28. These are the charges at issue in SOAH Docket No. 454-22-0040.M4-NP.

[32] Ex. 37. These are the charges at issue in SOAH Docket No. 454-22-0045.M4-NP.

[33] Ex. 47. These are the charges at issue in SOAH Docket No. 454-22-0039.M4-NP.

[34] Ex. 10 at SORM-000080; Ex. 24 at SORM-000147; Ex. 32 at SORM-000191; Ex. 41 at SORM-000224-25; Ex. 51 at SORM-000293.

[35] Ex. 10 at SORM-000080-81; *See also* 28 Tex. Admin. Code § 134.203(a)(7).

C. Analysis

SORM contends that reimbursement to Angleton was properly limited to four units per visit, consistent with the preauthorization letters and ODGs. Angleton contends that each of the preauthorization letters approved the total number of visits and treatments requested, without any limitation on the number of units that could be billed per visit, and therefore all of the billed units should be reimbursed.

The ALJ finds that the preauthorization requests and approvals cannot be reasonably construed as limiting physical therapy visits to four units or 60 minutes. While the preauthorization letters unequivocally state the number of sessions approved and the date range during which the services had to be provided, they do not clearly contain a time limit for each session. Rather, the letters state only that "treatment past 45-60 minutes requires documentation substantiating the medical necessity of the additional time." They do not indicate whether or not Angleton's preauthorization requests, which included medical records for the injured worker, had already established that medical necessity. Therefore, the ALJ agrees with the MFD Decisions' determination that SORM failed to include the "number of specific health care treatments and *the specific period of time requested to complete the treatments*" in the preauthorization letters.[36]

Further, even if the preauthorization letters could be construed as limiting the duration of each session, that limitation would not apply because SORM was prohibited from changing Angleton's preauthorization requests, or conditioning its approval of the requests, without first discussing the change with and documenting the approval of Angleton. Under 28 Texas Administrative Code § 134.600(n), "[t]he insurance carrier shall not condition an approval or change any elements of the [preapproval] request . . . unless the condition or change is mutually

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[36] Ex. 10 at SORM-000080; Ex. 24 at SORM-000147; Ex. 32 at SORM-000191; Ex. 41 at SORM-000224-25; Ex. 51 at SORM-000293 (emphasis added).

[37] 28 Tex. Admin. Code § 134.600(n).

agreed to by the health care provider and insurance carrier and is documented."[37] Nowhere in the preauthorization requests did Angleton limit its request for preauthorization to only four units per session. By limiting its approval to only four units per session without first reaching an agreement with Angleton, SORM has impermissibly conditioned or changed an element of the preauthorization request in violation of the Division's rules.

The ALJ further finds that Angleton's treatment of the injured worker was consistent withthe ODGs. The ODGs state that although it is typical for a physical therapy session to last only 45-60 minutes, more treatment time may be required for some patients and the guidelines do "notintend[] to limit or cap the number of units that are medically necessary for a particular patient."[38]The ODGs provide that an insurance carrier may authorize additional units if medically necessarydue to the individual patient's needs. In this case, Angleton's preauthorization requests demonstrated that five or more procedure codes were medically necessary for the patient; the requests were supported by medical documentation and did not limit treatment to only four units per session. Therefore, the preponderance of the evidence shows that the additional units per session were medically necessary and appropriate for this patient and complied with the ODGs.

In sum, for the reasons stated in this decision, the ALJ finds that SORM cannot limit the number of units in the absence of agreement with Angleton. Further, Angleton's preauthorization requests for treatment of the injured worker were consistent with the ODGs, and SORM should reimburse Angleton for those health care services not previously paid.[39] The ALJ concludes that the MFD Decisions correctly determined that SORM is required to pay to Angleton the disputed amount of $1,369.58 in Case No. 454-22-0043.M4-NP; $531.31 in Case No. 454-22-0044.M4-NP; $348.86 in Case No. 454-22-0040.M4-NP; $241.22 in Case No. 454-22-0045.M4-NP; and $389.73 in Case No. 454-22-0039.M4-NP, for a total reimbursement of $2,880.70.

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[38] Ex. 5 at SORM-000012-13.

[39] Though not cited by either party, the same conclusions were reached by ALJ Kerrie Qualtrough in a previous SOAH docket, 454-14-3636.M4-NP (Decision and Order issued September 14, 2014). The undersigned ALJ finds Judge Qualtrough's Decision and Order more persuasive than the 2008 and 2011 decisions cited by SORM. Exs. 7-9.

The ALJ makes the following findings of fact and conclusions of law in support of this decision.

III. FINDINGS OF FACT

1. In February 2020, a physician ordered physical therapy "2-3 days per week for 4 weeks" to treat an injured worker's left arm and shoulder. The injured worker became a patient of Angleton Rehabilitation and Wellness (Angleton).

2. The State Office of Risk Management (SORM) was the responsible workers' compensation insurer for the injured worker.

3. SORM contracts with CareWorks to perform workers' compensation medical bill reviews for SORM.

4. Angleton requested preauthorization for two or three physical therapy visits per week for four weeks.

5. CareWorks reviewed the claim and approved the services or treatment, agreeing that they were medically necessary or appropriate. The February 26, 2020 preauthorization letter approved 12 physical therapy visits from February 26-May 31, 2020.

6. In March 2020, Angleton submitted a preauthorization request for an additional 12 sessions of physical therapy, which CareWorks approved from March 27-June 27, 2020, in a letter dated March 27, 2020.

7. In April 2020, Angleton submitted a preauthorization request for an additional 12 sessions of physical therapy, which CareWorks approved from April 29-July 15, 2020, in a letter dated April 29, 2020.

8. In June 2020, Angleton submitted a preauthorization request for an additional 14 sessions of physical therapy, which CareWorks approved July 2, 2020-January 31, 2021, in a letter dated July 2, 2020.

9. Each of the preauthorization requests specified the number and frequency of sessions proposed. All but the initial preauthorization request specified the procedure codes (CPT codes) for the treatments, referencing between five and ten CPT codes per request.

10. Angleton requested approval of all procedure codes or modalities on the basis that all were medically necessary and appropriate for the patient.

11. None of Angleton's preapproval requests specified how long was requested to complete the treatments at each session.

12. Angleton did not limit the requests for approval to only four units per session.

13. Each approval letter set a date range for the approved services and stated that treatment past 45-60 minutes required documentation substantiating the medical necessity for more time.

14. The approval letters did not indicate whether Angleton's preauthorization requests, which included medical records for the injured worker, had or had not already established the medical necessity for longer visits.

15. Prior to issuing its approvals, SORM did not contact Angleton about limiting the number of units per session.

16. The approval letters cannot be reasonably construed as limiting physical therapy visits to four units or 60 minutes.

17. Angleton provided physical therapy to the injured worker at a number of visits beginning February 27, 2020.

18. Angleton requested and provided treatment in accordance with the Official Disability Guidelines (ODGs). The ODGs are used to determine if a modality is medically necessary and appropriate.

19. Although the ODGs provide that physical therapy sessions typically last only 45-60 minutes with three or four modalities or procedural units per visit, the ODGs acknowledge that some patients require more treatment time.

20. The ODGs do not limit or cap the number of units that are medically necessary for a particular patient at each visit.

21. Angleton's preauthorization requests demonstrated that five or more procedure codes were medically necessary for the patient. The requests were supported by medical documentation and did not limit treatment to only four units per session.

22. On the health insurance claim forms seeking reimbursement, services are billed in 15-minute increments, or units. Angleton submitted its bills to SORM and requested payment for four or more units per each session for a number of sessions.

23. SORM approved reimbursement for only four units per visit and denied payment for other units on the grounds that those charges had not been preauthorized and/or exceeded the preauthorization.

24. Angleton requested a Medical Fee Dispute (MFD) resolution from the Texas Department of Insurance, Division of Workers' Compensation (Division).

25. On August 27, 2020, the Division issued an MFD Decision ordering SORM to pay $1,369.58 in additional reimbursement to Angleton for physical therapy services provided from February 27-March 31, 2020.

26. On September 25, 2020, the Division issued an MFD Decision ordering SORM to pay $531.31 in additional reimbursement to Angleton for physical therapy services provided from April 1-23, 2020.

27. On October 15, 2020, the Division issued an MFD Decision ordering SORM to pay $348.86 in additional reimbursement to Angleton for physical therapy services provided from May 6-21, 2020.

28. On November 19, 2020, the Division issued an MFD Decision ordering SORM to pay $241.22 in additional reimbursement to Angleton for physical therapy services provided from May 27-June 3, 2020.

29. On January 29, 2021, the Division issued an MFD Decision ordering SORM to pay $389.73 in additional reimbursement to Angleton for physical therapy services provided from July 8-22, 2020.

30. Angleton timely requested a hearing at the State Office of Administrative Hearings (SOAH) to contest each of the MFD Decisions. The cases were docketed separately at SOAH.

31. On September 8, 2021, the Division issued a notice to the parties in each case with a statement of the nature of the hearings; the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

32. On October 15, 2021, the Administrative Law Judge (ALJ) issued Order No. 2 joining thefive cases into a single proceeding for all purposes other than appeal. Order No. 2 also included a statement of the time and place of the hearing and instructions for participating in the hearing.

33. On January 25, 2022, ALJ Sarah Starnes convened a hearing on the merits via the Zoom government videoconferencing platform before SOAH in Austin, Texas. SORM appeared through attorney Deea Western. Angleton appeared through its non-attorney representative, Keith Pesnell. The record closed at the conclusion of the hearing on that

same date.

IV. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order. Tex. Lab. Code § 413.031; Tex. Gov't Code ch. 2003.

2. Adequate and timely notice of the hearing was provided to the parties. Tex. Gov't Code §§ 2001.051-.052.

3. A medical fee dispute is a dispute over the amount of payment for services that have been determined to be medically necessary and appropriate for treatment of an injured employee's compensable injury. 28 Tex. Admin. Code § 133.305(a)(5).

4. A healthcare provider must request preauthorization from an injured worker's insurance carrier prior to providing physical therapy to the worker. Tex. Labor Code § 413.014(c)(4); 28 Tex. Admin. Code § 134.600(f), (p)(5).

5. The Texas Department of Insurance has adopted the ODGs for workers' compensation medical treatment in Texas, and treatment provided in accordance with the ODGs is presumed reasonable. 28 Tex. Admin. Code § 137.100(c)-(d).

6. When an insurance carrier approves a preauthorization request, the approval must include the specific health care, the approved number of treatments and specific period of time to complete the treatments, and notice of any unresolved dispute regarding the denial of compensability or liability. 28 Tex. Admin. Code § 134.600(l).

7. An insurance carrier may not condition an approval or change any elements of the request unless the condition or change is mutually agreed to by the health care provider and insurance carrier and is documented. 28 Tex. Admin. Code § 134.600(n).

8. By limiting the approval to only four units per session without first contacting Angleton and reaching agreement on that limitation, SORM impermissibly conditioned or changed an element of the preauthorization request. 28 Tex. Admin. Code § 134.600(n).

9. Angleton is entitled to receive a total of $2,880.70 for the physical therapy provided to the injured worker and not paid for by SORM as follows:

    a. $1,369.58 for physical therapy services provided from February 27-March 31, 2020 (Case No. 454-22-0043.M4-NP);

    b. $531.31 for physical therapy services provided from April 1-23, 2020 (Case No. 454-22-0044.M4-NP);

c. $348.86 for physical therapy services provided from May 6-21, 2020 (Case No. 454-22-0040.M4-NP);

d. $241.22 or physical therapy services provided from May 27-June 3, 2020 (Case No. 454-22-0045.M4-NP); and

e. $389.73 for physical therapy services provided from July 8-22, 2020 (Case No. 454-22-0039.M4-NP).

ORDER

IT IS ORDERED that Carrier must pay Provider the additional sum of $2,880.70, plus accrued interest.

NONPREVAILING PARTY DETERMINATION

Texas Labor Code § 413.0312(g) and 28 Texas Administrative Code § 133.307(h) require the nonprevailing party to reimburse the Division for the cost of services provided by SOAH. Texas Labor Code § 413.0312(i) requires SOAH to identify the nonprevailing party and any costs for services provided by SOAH in its final decision. For purposes of Texas Labor Code § 413.0312, SORM is the nonprevailing party. The costs associated with this decision are set forthin Attachment A to this Decision and Order and are incorporated herein for all purposes.

SIGNED February 25, 2022.

SARAH STARNES
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS