OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 5-260-718-002

ISSUES

1. Whether Claimant has proven by a preponderance of the evidence that Insurer failed to timely deny the requested treatment pursuant to WCRP Rule 16-7.[1]

2. If Insurer failed to timely deny the requested treatment, whether Claimant must prove by a preponderance of the evidence that the bilateral transforaminal epidural steroid injections at L3-L4 recommended by Dr. Tam Nguyen are reasonable, necessary, and casually related to Claimant's December 4, 2023 work injury.

FINDINGS OF FACT

1. Claimant is a 63-year-old male employed as a material handler with Employer. Claimant suffered an admitted work injury on December 4, 2023. Ex. C.

2. On December 15, 2023, Claimant underwent a lumbar posterolateral fusion at L4-L5 and L5-S1 with Daniel Robert Possley, D.O. at Platte Valley Hospital. Ex. J.

3. Between December 2023 and August 2024, Claimant participated in physical therapy for his lower back, Ex. O, and he attended follow-up appointments for his lumbar posterolateral fusion with Lee Michael Fonseca, N.P., at Plate Valley Clinic – Spine, Ex. L.

4. On July 6, 2024, Nurse Fonseca recommended Claimant undergo bilateral transforaminal epidural steroid injections (TFESI) at L3-L4 based on Claimant "having some right leg weakness [at] the L4 dermatome distribution of the leg." Ex. L p. 147-48; *see* Ex. K p. 110.

5. Claimant was referred to Premier Spine & Pain Institute for the bilateral TFESI at L3-L4.

6. On August 23, 2024, Shandria Fontaine from Premier Spine & Pain Institute sent a fax to Insurer requesting prior authorization for the bilateral TFESI at L3-L4. Ex. N. Tam Nguyen, M.D., is the requesting provider. *Id.*

7. Claimant was scheduled to undergo the bilateral TFESI at L3-L4 on September 3, 2024. Ex. N.

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[1] The ALJ refers to the Workers' Compensation Rules of Procedure in effect on August 23, 2024, the date the prior authorization request at issue was submitted to Insurer. The regulations in effect at that time can be found at https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=11530&fileName=7%20CCR%201101-3%20Rules%201-17 (last visited April 18, 2025).

8. Shaina Carter, a Senior Claims Representative with Insurer, testified at hearing. Ms. Carter credibly testified that she received the prior authorization request on August 23, 2024. *See* Ex. N p. 167.

9. Ms. Carter credibly testified that once she received the prior authorization request, she saved the request to Insurer's claim file and informed "central UR," Insurer's utilization review team, of the request.

10. Frank D. Polanco, M.D., completed a physician review of the prior authorization request for Insurer. Ex. M. Dr. Polanco recommended denying the requested bilateral TFESI at L3-L4. *Id.*

11. Dr. Polanco's recommendation is dated August 30, 2024. Ms. Carter credibly testified that she did not receive the recommendation until the early afternoon of September 3, 2024.

12. Ten days from August 23, 2024 was September 2, 2024. September 2, 2024 was the Labor Day holiday.

13. Ms. Carter credibly testified that on September 3, 2024, once she received Dr. Polanco's recommendation, she called and spoke to Ms. Fontaine at Premier Spine & Pain Institute to tell her that Insurer was denying the requested TFESI.

14. Mike Koons, Medical Operations Central Utilization Review Manager for Insurer, also testified at hearing.

15. On September 3, 2024, at 3:15 p.m., Mr. Koons sent Ms. Fontaine an email stating "[a]ttached is the denial and reviewer's opinion that Shaina mentioned would be coming." Ex. N p. 168. Attached to that email is a letter dated September 4, 2024 denying the requested TFESI. Ex. N p. 171.

16. Ms. Carter credibly testified that when correspondence is placed into Insurer's system, it is available for review online at that time but that hard copies are mailed to the parties the following day. For that reason, the letter attached to Mr. Koons email is dated September 4, 2024 despite being created on September 3, 2024.

17. Insurer did not email Claimant, Claimant's counsel, or Employer on September 3, 2024 to inform them of the denial. Ms. Carter credibly testified that the letter denying the prior authorization request was mailed by Insurer to Claimant, Claimant's counsel, and Employer on September 4, 2024.

18. Claimant did not undergo the bilateral TFESI at L3-L4 on September 3, 2024. Claimant credibly testified at hearing that he did not attend his appointment on September 3, 2024 because a nurse at Premier Spine & Pain Institute informed his wife that Insurer had denied the procedure.

19. Dr. Polanco testified at hearing and was admitted as an expert in occupational medicine and pain management. Dr. Polanco testified that:

a. The requested bilateral TFESI at L3-L4 did not meet the Medical Treatment Guidelines criteria in WCRP Rule 17 Exhibit 1. Particularly, the medical records he reviewed did not establish that Claimant was experiencing severe radicular pain, had positive straight leg raise tests, or had imaging reflecting nerve impingement. *See* Rule 17 Exhibit 1 Section 8 Recommendation 87.

b. Because Claimant's injury had occurred in December 2023, by August 2024 Claimant was no longer in the acute or subacute phase of his injury, which is the time in which TFESI are most effective. In his professional opinion, the risks of undergoing bilateral TFESI at this stage of Claimant's injury outweighs any potential benefit Claimant may receive.

20. The ALJ found Dr. Polanco's testimony generally unpersuasive. On cross-examination, Dr. Polanco conceded his review of Claimant's medical records did not include any records between January 6, 2024 and June 27, 2024. *See* Ex. M. Therefore, Dr. Polanco was missing approximately five of the eight months of post-injury records for Claimant when he came to the opinion that the requested bilateral TFESI was not reasonable or necessary. Dr. Polanco also admitted on cross-examination that he did not rely on his opinion that Claimant was beyond the acute and subacute phase of his injury when recommending denial and that he only reached that opinion upon re-reviewing his report for hearing.

21. Having reviewed the medical records, the ALJ gives greater weight to the recommendations of Claimant's treating providers (that the bilateral TFESI at L3-L4 is reasonable and necessary to treat the effects of Claimant's industrial injury) than Dr. Polanco's opinion to the contrary.

CONCLUSIONS OF LAW

The purpose of the Workers' Compensation Act of Colorado, section 8-40-101, *et. seq.*, C.R.S. is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. § 8-40-102(1). Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. § 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 318 (1979). The facts in a workers' compensation case must be interpreted neutrally; neither in favor of the rights of the claimant, nor in favor of the rights of respondents; and a workers' compensation claim shall be decided on the merits. § 8-43-201, C.R.S.

Assessing the weight, credibility, and sufficiency of evidence in Workers' Compensation proceedings is the exclusive domain of the administrative law judge. *Univ. Park Care Ctr. v. Indus. Claim Appeals Off.*, 43 P.3d 637, 641 (Colo. App. 2001). Even if other evidence in the record may have supported a contrary inference, it is for the ALJ to

resolve conflicts in the evidence, make credibility determinations, and draw plausible inferences from the evidence. *Id*. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *Bodensieck v. Indus. Claim Appeals Off.*, 183 P.3d 684, 687 (Colo. App. 2008). The weight and credibility to be assigned expert testimony is a matter within the discretion of the ALJ. *Cordova v. Indus. Claim Appeals Off.*, 55 P.3d 186, 191 (Colo. App. 2002). To the extent expert testimony is subject to conflicting interpretations, the ALJ may resolve the conflict by crediting part or none of the testimony. *Colo. Springs Motors, Ltd. v. Indus. Comm'n*, 165 Colo. 504, 506 (1968).

The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Eng'g, Inc. v. Indus. Claim Appeals Office*, 5 P.3d 385, 389 (Colo. App. 2000).

Timeliness of Denial of Prior Authorization

This proceeding raises the questions of whether Insurer timely denied the prior authorization request for the bilateral TFESI at L3-L4 and, if not, what effect does the untimely denial have? For the reasons discussed below, the ALJ concludes that Insurer failed to comply in full with Rule 16-7 and, therefore, Insurer authorized the requested treatment. As a result, Claimant may undergo the bilateral TFESI at L3-L4 and Insurer must pay for that treatment. Because of the untimely denial, and under the circumstances of this claim, the ALJ concludes Claimant does not have to establish that the requested bilateral TFESI at L3-L4 is causally related, reasonable, and necessary to cure and relieve the effects of his industrial injury because the treatment has been deemed authorized.

Rule 16 contains utilization standards "to assure the quick and efficient delivery of medical benefits at a reasonable cost." Rule 16-1. Rule 16-7 addresses the prior authorization process by which a provider can request authorization to guarantee payment for treatment requested and approved. *See* Rule 16-2(R) (defining prior authorization as "a guarantee of payment for treatment requested in accordance" with Rule 16).

Rule 16-7 sets out the requirements of the prior authorization process for both requesting providers and payers. There is no contention in this proceeding that the prior authorization request submitted by Dr. Nguyen was incomplete, *see* Rule 16-7(C), or was for a treatment for which a prior authorization is not to be requested, *see* Rule 16-7(A).

Under Rule 16-7(B) when a prior authorization request is received "the payer *shall respond* to all Prior Authorization requests *in writing within 10 days* from receipt of a completed request as defined per this Rule." (emphasis added).

> If the payer is denying a request for medical reasons, the payer *shall*, *within 10 days of receipt of the complete request*: Furnish the requesting [authorized treating provider (ATP)] *and the parties* with a *written denial* that sets forth an explanation of the specific medical reasons for the denial, including the name and professional credentials of the provider performing the medical review and a copy of the reviewer's opinion; the specific citation from the MTGs, when applicable; and identification of the information deemed most likely to influence a reconsideration of the denial, when applicable.

Rule 16-7-1(B)(2)(b) (emphasis added). "Failure of the payer to timely comply *in full* with all Prior Authorization requirements outlined in this rule *shall be deemed authorization* for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding." Rule 16-7-2(E) (emphasis added).

Here, the credible evidence establishes the following timeline of events:

- A complete prior authorization request was received by Insurer on August 23, 2024.

- Ten days from August 23, 2024 was September 2, 2024. Because September 2, 2024 was the Labor Day holiday, Insurer had to respond in writing to "the requesting ATP and the parties", Rule 16-7-1(B)(2)(b), by September 3, 2024. *See* Rule 1-2(B) (computation of time).

- On September 3, 2024, Insurer provided Premier Spine & Pain Institute, the requesting ATP, with a written denial of the prior authorization request.

- On September 4, 2024, Insurer provided the parties – Claimant, Claimant's attorney, and Employer – with written denial of the prior authorization request.

Respondents acknowledge that Claimant, Claimant's attorney, and Employer were not provided written denial of the prior authorization request by September 3, 2024. However, Respondents contend that when Insurer sent Ms. Fontaine at Premier Spine & Pain Institute a written denial of the prior authorization request, they substantially complied with Rule 16-7-1(B)(2)(b). *See EZ Bldg. Components Mfg., LLC v. Indus. Claim Appeals Off.*, 74 P.3d 516 (Colo. App. 2003); *Koontz v. Bowser Boutique, Inc.*, W.C. No. 4-359-795 (ICAO, Jan. 13, 2012). Further, because Claimant was informed by Premier Spine & Pain Institute that Insurer had denied the request, Respondents argue that Claimant had actual knowledge of the denial on September 3, 2024.

The ALJ finds no support for Respondents' "substantial compliance" argument in Rule 16-7. Rather, the plain language of Rule 16-7-2(E) requires the payer "comply in full" and, if it fails to do so, the treatment requested "shall be deemed authorized for

payment." *See Gomez v. JP Trucking, Inc.*, 2022 CO 21, ¶ 27 ("[A]s with a statute, if the language of a regulation is unambiguous, we enforce it as written, giving the words and phrases their common and ordinary meaning."). Here, Rule 16-7-1(B)(2)(b) required Insurer to provide *written* notice to the provider *and the parties* by September 3, 2024. Because that did not happen, Insurer did not "comply in full" with the rule and, by operation of Rule 16-7-2(E), the treatment has been deemed authorized.

The ALJ further concludes that the result of the treatment being "deemed authorized" by failure to timely deny is that Claimant does not have to establish at hearing that the treatment is casually related, reasonable, and necessary. Any other interpretation of Rule 16-7-2(E) would render the timeliness requirements of Rule 16-7 meaningless since any payer could ignore the time requirements of the rule and then challenge the treatment on the grounds it is not casually related, reasonable, and/or necessary, resulting in the rule's "deemed authorized" consequence for failure to timely deny having no effect.

Respondents' cite *Bekkouche v. Riviera Electric*, W.C. No. 4-514-998 (ICAO, May 10, 2007) for the proposition that the ALJ retains jurisdiction to determine whether the requested treatment is reasonable and necessary even when Rule 16 is violated. In *Bekkouche*, the claimant was attending ongoing chiropractic treatments. An application for hearing was filed endorsing the issue of medical benefits to determine the compensability of those treatments. On appeal to the Panel, the claimant argued that because the respondents had not timely denied prior authorization under Rule 16, the respondents were precluded from seeking an adjudication of their liability for those medical benefits from an ALJ. The Panel disagreed with the claimant and concluded that "respondents' default under Rule 16 only required them to provide the ongoing chiropractic care until the matter was resolved by an administrative law judge following a hearing." According to the Panel, "we decline to read Rule 16 to require the defaulting insurer to pay for ongoing treatment indefinitely, with no recourse to the adjudicative procedures."

But in this matter, the prior authorization request is for a single treatment which the Insurer has not paid for. Interpreting Rule 16-7 to allow Respondents' to challenge that treatment here would mean that Insurer's failure to comply in full with the rule had no legal effect despite the rule's clear directive that failure to comply results in a treatment being "deemed authorized." The ALJ considered the possibility that when a payer fails to comply with Rule 16-7, the legal effect should be that the burden shifts from the claimant to prove the treatment is causally related, reasonable, and necessary to the respondents to prove that the authorization was error, but there is simply no authority supporting that type of burden-shifting at this time. Rather, the ALJ is compelled to conclude that when Insurer failed to comply in full with Rule 16-7, it authorized the bilateral TFESI at L3-L4 and Claimant is entitled to undergo that treatment knowing Insurer will pay for it.

ORDER

It is therefore ordered that:

1. Insurer failed to comply in full with Rule 16-7-1(B)(2)(b) when denying Claimant's prior authorization request for bilateral TFESI at L3-L4. Therefore, by operation of Rule 16-7-2(E), Insurer authorized the treatment and must pay for that treatment. As Insurer has authorized payment for the requested treatment, Claimant need not prove by a preponderance of the evidence that the requested bilateral TFESI at L3-L4 is casually related, reasonable, and necessary to relieve the effects of his industrial injury.

2. All matters not determined herein are reserved for future determination.

SIGNED: April 18, 2025.

Robin E. Hoogerhyde
Administrative Law Judge

If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman St., 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference see section 8-43-301(2), C.R.S. For further information regarding procedures to follow when filing a Petition to Review, see O.A.C.R.P. Rule 27. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.