SOAH DOCKET NO. 454-08-2769.M4
MR NO. M4-08-2301-01

TEXAS HEALTH LLC, **Petitioner**	§	**BEFORE THE STATE OFFICE**
vs.	§	**OF**
TEXAS MUTUAL INSURANCE CO., **Respondent**	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER ON MOTIONS FOR SUMMARY DISPOSITION

I. INTRODUCTION

Texas Mutual Insurance Company (Carrier) filed a Motion for Summary Disposition (Carrier's Motion), contending that the claim for payment submitted by Texas Health LLC (Provider) in this case should be denied because Provider was required to obtain preauthorization for the services rendered, but failed to do so. Provider filed a response and its own Motion for Summary Disposition (Provider's Motion). Provider contended that preauthorization was not required under a correct construction of applicable rules and that its claim should be paid. There was no dispute as to the material facts. This decision agrees with Carrier and rules that Carrier is not required to pay the claim.

Carrier's Motion was filed on August 6, 2008. Provider filed a response and its Motion on August 11, 2008. A pre-hearing conference convened to hear the motions on September 4, 2008, at the State Office of Administrative Hearings. Carrier was represented by Attorney Bryan W. Jones. Provider was represented by Attorney Matthew B. Lewis. The record closed on September 4, 2008.

II. DISCUSSION

A. Background

1. Evidence and Undisputed Facts

On August 6, 2008, Carrier filed a Motion for Official Notice of certain matters and a Motion to Admit Certain Exhibits. It requested that official notice be taken of 28 TEX. ADMIN. CODE (TAC) §§ 134.600 and 137.100; a page from the Texas Department of Insurance, Division of Workers' Compensation (Division), ODG and Preauthorization Process Q & As; and Division Medical Fee Dispute Resolution Findings and Decision, MFDR Tracking #M4-08-3730-01 and MFDR Tracking # M4-08-4324-01. There was no objection to this request. The ALJ granted the request and took official notice of those documents during the September 4, 2008 pre-hearing conference.

Carrier requested the following documents be admitted into evidence: Medical Fee Dispute Resolution Findings and Decision, MFDR Tracking #M4-08-2301-01 (Ex. A); a table of disputed services for the injured worker (Claimant) (Ex. B); Provider's responses to Carrier's Request for Admissions (Ex.C); portions of the Official Disability Guideline (ODG) relating to treatment of the forearm, wrist, and hand (Ex.D); and various discovery documents, including copies of facsimile transmission pages and cover pages for Carrier's First Set of Interrogatories, Requests for Production, and Requests for Admission to Provider, and Carrier's Requests for Admissions, and Provider's responses to the requests. (Ex. I). There was no objection to this request. The ALJ granted the request at the September 4, 2008 prehearing conference and the documents were entered into evidence.

Provider requested that its submission of documents, which consists of 382 pages of records, be considered with its Motion as if attached to the Motion and that official notice be taken of a list of CARF Accredited Work Hardening & Work Conditioning Programs Exempted from Preauthorization and Concurrent Review, beginning on page 359 of Provider's documents and specifically page 378, where Provider is shown as an exempt facility for work conditioning

and work hardening at the time of disputed services (July 25, 2007, through September 17, 2007). There was no objection to this request. The ALJ granted the request on September 4, 2008, and took official notice of the matters requested. With regard to Provider's request that he also consider the other pages of its records, the ALJ considered the pages cited by Provider.

At the beginning of its Motion, Carrier listed 14 facts that it said could not reasonably be disputed. Provider did not dispute these facts and incorporated them by reference in support of its Motion. These facts are set forth as follows:

1. This dispute arises for [from] a findings and decision of the Medical Fee Dispute Resolution section (MFDR) of the Texas Department of Insurance—Division of Workers Compensation (DWC) in MDR Tracking # M4-08-2301-01, *Findings and Decision, MDR Tracking # M4-08-2301-01*.

2. Provider billed Carrier for work hardening services, CPT Code 97545 and 97546 for the dates of service July 25, 2007 through September 17, 2007.

3. Carrier denied reimbursement with the following codes: 62—Payment denied/reduced for absence of, or exceed, pre-certification/authorization; 930—Pre-authorization required, reimbursement denied; W4-No additional reimbursement allowed after review of appeal/reconsideration; 891—The insurance company is reducing or denying payment after reconsideration; 18—Duplicate claim/service, 224—Duplicate charge.

4. Provider requested dispute resolution from the Texas Department of Insurance—Division of Workers Compensation.

5. The services in dispute occurred after May 1, 2007 and before September 25, 2007.

6. The CMS 1500 billing forms for the services in dispute list 842.00 as the diagnostic code in box 21.

7. Diagnostic code 842.00 is used for "sprain of unspecified site of wrist."

8. At the time the services in dispute were provided, the *Official Disability Guideline (ODG)* did not address work hardening for diagnostic code 842.00 (sprain of unspecified site of wrist).

9. Division Rule 134.600(p) (12) provides that preauthorization is required for 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.

10. The Division requires that health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines – Treatment in Workers' Comp*, excluding the return to work pathways.

11. The services in dispute were not preauthorized by Carrier.

12. Division Rule 134.600(p)(4) sets forth the following: "(p) Non-emergency health care requiring preauthorization includes: (4) all non-exempted work hardening or non-exempted work conditioning programs."

13. Division Rule 134.600(p)(12) sets forth the following: "(p) Non-emergency health care requiring preauthorization includes: (12) 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."

14. Division Rule 137.100(a) sets forth the following: "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines – Treatment in Workers Comp*, excluding the return to work pathways (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with § 134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or § 137.300 of this title (relating to Required Treatment Planning)."

2. Controlling Law

This section quotes the law controlling this case and is a partial repetition of some of the rules quoted in the previous section. TEX. LABOR CODE ANN. § 413.014 provides the following, in pertinent part:

> **§ 413.014. PREAUTHORIZATION REQUIREMENTS; CONCURRENT REVIEW AND CERTIFICATION OF HEALH CARE.**
>
> . . .
>
> (b) The Commissioner by rule shall specify which health care treatments and services require express preauthorization or concurrent review by the insurance carrier. Treatments and services for a medical emergency do not require express preauthorization. . . .
>
> (c) The commissioner's rules adopted under this section must provide that preauthorization and concurrent reviews are required at a minimum for: . . .

(2) work-hardening or work conditioning services provided by a health care facility that is not credentialed by an organization recognized by commissioner rules. . . .

(e) The 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.

The Division's rules at 28 TAC § 134.600 provide the following, in pertinent part:

Rule 134.600. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise: . . .

(4) Division exempted program: a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited work conditioning or work hardening program that has requested and been granted an exemption by the Division from preauthorization and concurrent review requirements. . . .

(7) Preauthorization: prospective approval obtained from the insurance carrier (carrier) by the requestor or injured employee (employee) prior to providing the health care treatment or services (health care). . . .

(b) When Division-adopted treatment guidelines conflict with this section, this section prevails.

(c) The carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

(C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or

(D) when ordered by the Commissioner; or . . .

(e) The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. . . .

(p) Non-emergency health care requiring preauthorization includes:

. . .

(4) all non-exempted work hardening or non-exempted work conditioning programs. . . .

(12) 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 . . .

The Division's rules at 137.100 provide the following in pertinent part:

Rule 137.100. Treatment Guidelines

(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines – Treatment in Workers Comp,* excluding the return to work pathways (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with § 134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or § 137.300 of this title (relating to Required Treatment Planning). . . .

(d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:

(1) the treatment(s) or service(s) were provided in a medical emergency; or

(2) the treatment(s) or service(s) were preauthorized in accordance with § 134.600 or 137.300 of this title. . . .

(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with § 134.600 of this title, or may be required to submit a treatment plan in accordance with § 137.300 of this title.

3. Party Positions

The parties agreed at the September 4, 2008 pre-hearing conference that this matter can be disposed of by summary disposition because there is no genuine issue of any material fact and the matter may be resolved based purely on a consideration of applicable law.

Carrier cited the Division's website, which said in question and answer (Q & A) format that an exempted CARF facility is required to obtain preauthorization when the service is not recommended in the ODG or exceeds the number or duration listed in the ODG.

Carrier disputed Provider's argument that Rule 134.600(p)(4) means that exempted work hardening/work conditioning programs do not ever require preauthorization. It pointed out that the rule simply says that non-exempt programs require preauthorization, not that exempt programs can never require preauthorization. It contended that the requirements of subsection (p)(12), requiring preauthorization for services that exceed or are not addressed by the ODG guidelines and are not contained in the treatment plan preauthorized by the insurance carrier, is a stand-alone provision that requires preauthorization under the circumstances addressed by the rule, regardless of whether a program is exempt or nonexempt. It said Provider is simply asking the ALJ to ignore subsection (p)(12) for division-exempted programs.

Carrier argued that the subsection (a)(4) definition of "Division exempted program," which would otherwise indicate that CARF-accredited programs are automatically excepted from preauthorization requirements, is not applicable in this case because the lead-in to the definitions in subsection (a) is specifically qualified by the words, "unless the context clearly indicates otherwise." It argued that the context of subsection (p)(12), requiring preauthorization for services that exceed or are not addressed by the treatment guidelines, is a context that clearly indicates "otherwise" than subsection (a)(4).

Carrier cited a portion of the rule-preamble to Rule 134.600, which provides as follows:

> Treatments and services covered within the treatment guidelines will continue to require preauthorization or concurrent review if they are included on the lists in

> subsection (p) or (q). Treatments and services not covered within the treatment guidelines and not specifically included on the lists in subsection (p) or (q) will require preauthorization per subsection (p)(12).[1]

Carrier argued that the Division was explaining in the second sentence that subsection (p)(12) is a catchall to require preauthorization for services not covered within the treatment guidelines and not already specifically included in the subsection (p) and (q) lists. It argued that because exempted work-hardening services are not specifically included in subsections (p) and (q), they require preauthorization.

Provider argued that a plain reading of subsection (p)(4) indicates that exempted work hardening/work conditioning programs like its program are not required to obtain preauthorization. It contended that the exemption is meaningless if preauthorization is required under certain circumstances. In support of its position, it cited Rule 134.600(a)(4), which refers to programs that "have been granted an exemption . . . from preauthorization . . . requirements." It pointed out that the words do not say "sometimes exempted" from preauthorization requirements. It contended that it does not matter that the services were not recommended by the ODG because Rule 134.600(b) provides that Rule 134.600 prevails in the case of a conflict with Division-adopted treatment guidelines.

Provider also focused on the second sentence of the above-quoted preamble to Rule 134.600 and argued that subsection (p)(12) does not apply in this case because the services it (Provider) provides, work hardening and work conditioning, are specifically addressed in subsection (p), namely at (p)(4). Provider contended that the preamble focuses on the types of services provided, not the type of provider (whether CARF accredited or not). Because subsection (p)(4) specifically addresses the types of services it (Provider) provides (work hardening and work conditioning), those services are "listed" in subsection (p) and therefore, subsection (p)(12) does not apply.

[1] 31 TexReg 3571.

Provider maintained that the Q & A statement on the Division's website that exempted programs are required to obtain preauthorization when treatment exceeds ODG recommendations is of no consequence because it is not a statute, formally-adopted rule, or judicial interpretation. It argued that the identity or authority of the Division staff person who wrote the Q & A is unknown. It maintained the statement has no legal effect.

4. Analysis

The ALJ finds Carrier's position persuasive. Subsection (p)(12) clearly provides that services not covered by the treatment guidelines requires preauthorization. As Carrier argued, subsection (p)(4) does not address CARF-accredited programs at all. It simply says that non-CARF accredited programs will require preauthorization. Subsection (p) (4) certainly implies that, unlike non-CARF-accredited programs, CARF-accredited programs do not always require preauthorization, but it does not imply that they never will.

Likewise, there is no irreconcilable conflict between subsections (a)(4) and (p)(12) because the definition of "Division exempted program" in subsection (a)(4) is qualified by the lead in language in subsection (a) saying "unless the context clearly indicates otherwise." The context of subsection (p)(12), requiring preauthorization for services that exceed or are otherwise outside the guidelines, indicates "otherwise" than subsection (a)(4). Rules of construction provide that a direct conflict between statutory provisions is to be avoided where possible.[2] [3]

Of paramount significance, a later passed rule, § 137.100(d),[4] indicates that services provided in excess of the treatment guidelines require preauthorization. Subsection (d) provides:

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[2] *Jones v. State*, 225 S.W.3d 772, 782 (Tex. App.—Houston [14th] 2007, no writ).

[3] There is no reason that validly-enacted rules should not construed in the same manner as statutory law. Validly passed rules of an administrative agency acting within its authority have the force and effect of statutes. *The Insurance Company of the State of Pennsylvania v. Hartford Underwriters Insurance Company*, 164 S.W. 3d 747, 749 (Tex. App.—Houston [14th] 2005, no writ).

[4] Rule 137.100 was adopted to be effective on January 18, 2007. 32 TexReg 163.

(d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:

(1) the treatment(s) or service(s) were provided in a medical emergency; or

(2) the treatment(s) or service(s) were preauthorized in accordance with § 134.600 or 137.300 of this title.

Provider argued that the words "in accordance with" within the words "preauthorized in accordance with § 134.600" simply mean that Rule 134.600 should be applied in accordance with its terms, including provisions which say that preauthorization is not required for certain health care services *i. e.*, subsection (d)(2) is simply a restatement of Rule 134.600. The ALJ is not persuaded by this argument. The plain and precise meaning of the words "**were preauthorized** in accordance with § 134.600 . . ." (emphasis added) is that the service/treatment was preauthorized and done so in accordance with the terms of Rule 134.600. Rules of construction require that provisions be construed in accordance with their meaning.[5] Rule 137.100(d) confirms Rule 134.600(p)(12).[6]

The ALJ disagrees with Provider's construction of the preamble of Rule 134.600. Again, the sentence at issue provides, "[T]reatments and services not covered within the treatment guidelines and not specifically included on the lists in subsection (p) or (q) will require preauthorization per subsection (p)(12)." Provider's construction of this sentence as focusing on the words "treatments and services" only, without regard to the entity providing the service (whether exempt or nonexempt), to arrive at a conclusion that the services addressed in subsection (p)(4) (work hardening and work conditioning) are included in the subsection (p) list, is inconsistent with the plain wording of the rule. Provider is correct that Subsection (p)(4) does address specific services, but the "services . . . specifically . . . listed" are "all non-exempted

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[5] *In Re Estate of Nash*, 220 S.W. 3d 914, 917 (Tex. 2007).

[6] Provider cited Rule 134.600(b), which says, "When Division-adopted treatment guidelines conflict with this section, this section prevails." However, it appears that Rule 137.100 adopts a treatment guideline rather than being a treatment guideline itself.

work hardening or non-exempted work conditioning programs." This provision shows the Division's intent in drafting the rule. Case law holds that a reasonable agency interpretation of the legal standards it is charged with enforcing is entitled to great weight.[7]

Even if one were to accept Provider's argument that subsections (a)(4) and (p)(4) are in direct and irreconcilable conflict with subsection (p)(12) (and also subsection (c)),[8] rules of construction would indicate that subsection (p)(12) should nonetheless prevail. Rule 137.100(d) would resolve the conflict. As a general rule, as between two conflicting provisions, the last-enacted provision prevails.[9]

Even if Rule 137.100 is ignored, subsection (p)(12) should be construed as controlling under applicable rules of construction. Subsection (p)(12) addresses specific limited circumstances in which preauthorization is required in contrast with the general principle stated in subsection (a)(4) that CARF-accredited programs do not require preauthorization. If a conflict between a general provision and a special or local provision is irreconcilable, the special or local provision prevails as an exception to the general provision, unless the general provision is the later enactment and the manifest intent is that the general provision should prevail.[10] Subsections (a)(4) and (p)(12) were adopted at the same time.[11]

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[7] *Osterberg v. Peca*, 12 S.W. 3rd 31, 51 (Tex. 2000).

[8] Subsection (c) of Rule 134.600 should also been seen as conflicting with subsection (a)(4) (assuming Provider's argument that a conflict exists is accepted). It provides that carriers are liable for medical costs for care listed in subsections (p) and (q) only in the case of an emergency, preauthorization under subsection (p), concurrent review under subsection (q), or when ordered by the Commissioner. Since subsection (p)(4) does not address exempted programs, subsection (p)(12) is the only portion of subsection (p) that addresses Provider's program. Thus, in accordance with subsection (c), carriers are not liable for Provider's care listed in subsection (p) (the specific care in this case being Provider's services that fall under subsection (p)(12)), unless it was preauthorized (or provided in an emergency or ordered by the Commissioner).

[9] TEX. GOV'T CODE ANN. § 311.025.

[10] TEX. GOV'T CODE ANN. § 311.026; *City of Dallas v. Mitchell*, 870 S.W. 2d 21, 22 (Tex. 1994).

[11] 31 TexReg 3566.

Moreover, although Provider is correct that the Division's Q&A website is not a rule itself and the author of the Q & A is not known, rule interpretations on the Division's website obviously constitute direct or at least circumstantial evidence of the Division's interpretation of its rules. Again, an agency's interpretation of the regulations it is charge with enforcing is entitled to great weight.

As a final note, a look in isolation at the history surrounding the adoption of subsections (a)(4), (p)(4), and (p)(12) shows that subsection (p)(12) is the later expression of Division intent. Although all three subsections were added in 2006, the predecessor to both subsections (a)(4) and (p)(4), former subsection (h)(9), was enacted in 2002.[12] Subsection (h)(9) provided as follows:

> (h) The non-emergency health care requiring preauthorization includes: . . .
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> > (9) work hardening and work conditioning services provided in a facility that has not been approved for exemption by the commission. . . . (For commission exemption approval for programs initiated on or after March 15, 2004, facilities must submit documentation of current program accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) to the commission. . . .)[13]

In the preamble to its proposed 2006 amendment to Rule 134.600, the Division said the "proposed amendments to subsection (a) include additions of new terminology used in the section and reorganization of terminology from other sections for ease in reading."[14] It appears that new (2006) subsections (a)(4) and (p)(4) are essentially a reorganization of old subsection (h)(9). By contrast, new subsection (p)(12) is entirely new language expressing a new intent. On that basis as well as the other matters discussed above, subsection (p)(12) should be seen as controlling.

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[12] 27 TexReg 10329, 10332, 12359, 12364.

[13] 31 TexReg 818.

[14] See 31 TexReg 813. Subsection (a)(4) is one of three new provisions in subsection (a). 31 TexReg 815.

On the basis of the matters described above, Carrier's Motion for Summary Disposition will be granted and Provider's Motion will be denied.

III. FINDINGS OF FACT

1. This dispute arises from a findings and decision of the Medical Fee Dispute Resolution section (MFDR) of the Texas Department of Insurance—Division of Workers Compensation (DWC) in MDR Tracking # M4-08-2301-01, *Findings and Decision, MDR Tracking # M4-08-2301-01*.

2. Texas Health LLC (Provider) billed Texas Mutual Insurance Company (Carrier) for work hardening services, CPT Code 97545 and 97546 for the dates of service July 25, 2007 through September 17, 2007.

3. Carrier denied reimbursement with the following codes: 62—Payment denied/reduced for absence of, or exceed, pre-certification/authorization; 930—Pre-authorization required, reimbursement denied; W4-No additional reimbursement allowed after review of appeal/reconsideration; 891—The insurance company is reducing or denying payment after reconsideration; 18—Duplicate claim/service, 224—Duplicate charge.

4. Provider requested dispute resolution from the Texas Department of Insurance—Division of Workers Compensation.

5. The services in dispute occurred after May 1, 2007 and before September 25, 2007.

6. The CMS 1500 billing forms for the services in dispute list 842.00 as the diagnostic code in box 21.

7. Diagnostic code 842.00 is used for "sprain of unspecified site of wrist."

8. At the time the services in dispute were provided, the *Official Disability Guideline (ODG)* did not address work hardening for diagnostic code 842.00 (sprain of unspecified site of wrist).

9. The services in dispute were not preauthorized by Carrier.

10. The DWC Medical Review Division (MRD) denied Provider's claim based on its determination that Provider was required to obtain preauthorization for the services, but failed to do so.

11. Provider requested a hearing to contest the MRD decision.

12. 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.

13. All parties had an opportunity to respond and present evidence and argument on each issue involved in the case.

14. Division Rule 134.600(p)(12) provides that preauthorization is required for 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.

15. The Division requires that health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines – Treatment in Workers' Comp*, excluding the return to work pathways.

16. Division Rule 134.600(p)(4) sets forth the following: "(p) Non-emergency health care requiring preauthorization includes: (4) all non-exempted work hardening or non-exempted work conditioning programs."

17. Division Rule 134.600(p)(12) sets forth the following: "(p) Non-emergency health care requiring preauthorization includes: (12) 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."

18. Division Rule 137.100(a) sets forth the following: "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines – Treatment in Workers Comp,* excluding the return to work pathways (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with § 134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or § 137.300 of this title (relating to Required Treatment Planning)."

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, pursuant to TEX. LAB. CODE ANN. § 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. The services at issue required preauthorization by the Carrier. 28 TEX. ADMIN. CODE §§ 134.600(p)(12); 137.100(d).

4. Provider did not obtain preauthorization.

5. Carrier's Motion for Summary Disposition should be granted.

6. Provider's Motion for Summary Disposition should be denied.

7. Provider's claim should be denied.

ORDER

IT IS THEREFORE ORDERED that Texas Mutual Insurance Company's Motion for Summary Disposition be, and the same is hereby, **granted**.

IT IS ORDERED FURTHER that Texas Health LLC's Motion for Summary Disposition be, and the same is hereby, **denied**.

IT IS ORDERED FURTHER that Texas Mutual Insurance Company is not required to pay additional reimbursement to Texas Health LLC for the services in dispute in this case.

SIGNED September 18, 2008.

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JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS