CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4 (LEAD DOCKET)
MR NO. _____

RENAISSANCE HOSPITALS,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
ACE AMERICAN INSURANCE	§	
COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

This docket consolidated for hearing 113 cases (listed on Attachments A and B) because they involve the same basic legal issues and evidence (Consolidated Docket). Each case involves hospital outpatient services rendered by Renaissance Hospitals (Renaissance)[1] between 2002 and 2007 to an injured employee covered by the Texas workers' compensation insurance system. The Consolidated Docket involves multiple insurance carriers (Carriers) represented by the same attorney.

In each of the 113 cases, Renaissance filed a request for dispute resolution with the Medical Review Division (MRD) of the Texas Department of Insurance's Division of Workers' Compensation (Division).[2] The Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision) for each case. In 108[3] of the cases, the MRD Decision denied Renaissance's request for additional reimbursement. Renaissance timely requested a hearing in each of those cases. In five of the cases, the MRD Decision ordered Carriers to pay additional

[1] Renaissance Hospitals is in a Chapter 7 bankruptcy proceeding. Pursuant to an August 2010 Bankruptcy Court Order, the automatic stay was lifted to allow the Chapter 7 Bankruptcy Trustee for Renaissance to continue the claims adjudication process regarding workers' compensation receivables on behalf of the debtor's estate.

[2] Effective September 1, 2005, the legislature dissolved the Texas Workers' Compensation Commission (Commission) and created the Division of Workers' Compensation within the Texas Department of Insurance. Act of June 1, 2005, 79th Leg., R.S., ch. 265, § 8.001, 2005 Tex. Gen. Laws 469, 607. This Decision and Order refers to the Commission and its successor collectively as the Division.

[3] In its initial closing argument, Renaissance listed 109 cases. In its reply brief, Renaissance stated that one case had been misclassified because the carrier had requested the contested case hearing.

reimbursement to Renaissance. Carriers timely requested a hearing in each of those cases. All of the cases were consolidated under the lead docket captioned above.[4]

On November 21, 2013, two Administrative Law Judges (ALJs) of the State Office of Administrative Hearings (SOAH) convened the consolidated hearings on the merits at SOAH's offices in Austin, Texas. Renaissance was represented by attorney Patrick Hyde and Carriers were represented by attorney Steven M. Tipton. The record closed on February 7, 2014, after submission of written closing and reply briefs.

The parties agree that the issue to be addressed involves the determination of a fair and reasonable reimbursement for hospital outpatient services in each of the cases at issue.[5] Carriers submit that Renaissance has the burden of proof in all 113 cases. Renaissance takes the position that the party requesting the contested case hearing has the burden of proof. Carriers also argue that Renaissance may not rely upon theories of recovery not presented to the Division. Carriers further argue that, even if new theories can be raised for the first time before SOAH, Renaissance has not established that these theories meet the fair and reasonable standard.

After considering all of the evidence and arguments, the ALJs conclude that: (1) the party requesting the contested case hearing has the burden of proof; (2) Renaissance is entitled to present, and SOAH may consider, alternative methods of calculating reimbursement that may be fair and reasonable; (3) the application of the current Hospital Outpatient Facility Fee Guideline (Hospital Outpatient Guideline) methodology is an appropriate basis to determine fair and reasonable reimbursement; and, (4) this methodology generates the most reliable reimbursement calculations. Therefore, Renaissance is entitled to relief in the amounts indicated on Attachment C.

[4] The parties disagreed as to the assignment of the burden of proof in these contested cases. That is discussed below.

[5] The parties' dispute centers on the methodology of determining fair and reasonable reimbursements in general for a variety of outpatient services. The particular services themselves are pertinent for discussion only insofar as the theories of recovery submitted by Renaissance develop various pools of comparable procedures, as described further below.

II. APPLICABLE LAW

Workers' compensation insurance in Texas covers all medically necessary health care, which includes all reasonable medical aid, examinations, treatments, diagnoses, evaluations, and services reasonably required by the nature of the compensable injury and reasonably intended to cure or relieve the effects naturally resulting from a compensable injury. It includes procedures designed to promote recovery or to enhance the injured worker's ability to return to or retain employment.[6] Title 5, subtitle A, chapters 401 through 419 of the Texas Labor Code constitute the Texas Workers' Compensation Act (Act).

Act § 413.011 provides that the Division by rule shall establish medical policies and guidelines relating to fees charged or paid for medical services for employees who suffer compensable injuries, including guidelines relating to payment of fees for specific medical treatments or services. That section further provides that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.[7]

Moreover, the guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.[8] In setting such guidelines, the increased security of payment afforded by the Act must be considered.[9]

Where the Division has not established a fee guideline and where no negotiated contract exists, an insurance carrier shall reimburse the provider at fair and reasonable rates as described in Act § 413.011(d).[10] Until May 2, 2006, "fair and reasonable reimbursement" was defined as follows:

> Reimbursement that meets the standards set out in § 413.011 of the Texas Labor Code, and the lesser of a health care provider's usual and customary charge, or
>
> (A) the maximum allowable reimbursement, when one has been established in an applicable Commission fee guideline,

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[6] Tex. Lab. Code § 401.011(19) and (31). The Texas Workers' Compensation Act is found at Texas Labor Code chapters 401-419 (the Act).

[7] Act § 413.011(d).

[8] *Id.*

[9] *Id.*

[10] Currently, this provision is found at 28 Texas Administrative Code § 134.1(e)(3) and (f). From May 16, 2002, to May 2, 2006, it was at 28 Texas Administrative Code § 134.1(c), and from May 2, 2006, to March 2008, at 28 Texas Administrative Code § 134.1(c)(3) and (d).

> (B) the determination of a payment amount for medical treatment(s) and/or service(s) for which the Commission has established no maximum allowable reimbursement amount, or
> (C) a negotiated contract amount.[11]

Effective May 2, 2006, the Division defined "fair and reasonable reimbursement" as reimbursement that:

> (1) is consistent with the criteria of Labor Code § 413.011;
> (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and
> (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.[12]

III. DISCUSSION

A. Burden of Proof and Presentation of New Theories of Reimbursement

Renaissance and Carriers agreed that in at least 108 of the cases at issue, Renaissance bears the burden of showing by a preponderance of the evidence that the amount it seeks to recover is fair and reasonable. Carriers maintain that Renaissance has the burden of proof in the other five cases as well. Carriers also dispute whether Renaissance may raise new theories of reimbursement before SOAH that were not first presented to the Division. These issues are intertwined.

Carriers assert that Renaissance requested the MRD dispute resolution and, as the "requestor," had the burden of proving its entitlement to additional reimbursement at the Division. Because the SOAH hearing is *de novo*, Carriers argue that Renaissance continues to bear that burden of proof to show it is entitled to additional reimbursement. Carriers posit that Renaissance is the party seeking relief because it is the party seeking additional payment. Also, Carriers contend, Renaissance is limited to the arguments it presented before the Division because permitting it to offer additional arguments now would disadvantage Carriers and improperly circumvent the Division's role in considering the theories of recovery.

[11] 28 Tex. Admin. Code § 133.1(8).

[12] 28 Tex. Admin. Code § 134.1(d)(1)-(3). Effective March 1, 2008, it became 28 Texas Administrative Code § 134.1(f)(1)-(3).

For its part, Renaissance states that it has the burden of proof in the cases in which it seeks a contested case hearing before SOAH of the MRD Decision and that, if Carriers seek a contested case hearing at SOAH to challenge an MRD Decision in a given case, Carriers have the burden of proof in that case. Specifically, in the five cases listed on Attachment B, Renaissance contends that Carriers bear the burden of proof because they seek relief from MRD Decisions requiring additional payment to be made to Renaissance.

In proffering five new theories of recovery that were not presented to the Division, Renaissance cites Division precedent that permits supplemental information, including alternative theories of recovery. The only limitation, Renaissance argues, is that neither party may change the list of services in dispute. In other words, the provider may not allege before SOAH that additional services were provided, and the carrier, if it does not dispute the extent of treatment before the Division, can only dispute whether the payment amount is fair and reasonable.

SOAH hearings have historically involved a *de novo* review of the issues involved, and have not been simply a review of the propriety of the MRD Decision. Carriers assert that, per Texas Supreme Court precedent concerning which party is seeking relief in an appeal, and based on the Texas Legislature's "refusal to alter" the traditional assignment of the burden of proof in workers compensation law, a *de novo* hearing at SOAH maintains the burden of proof with the party who first requested the Division's medical dispute resolution.

Contrary to what Carriers argue, the *de novo* nature of SOAH hearings is not the result of specific statutes, applicable procedural rules, or case law requiring it. Rather, it has developed through past SOAH precedent—the same precedent that for more than 10 years has almost uniformly placed the burden of proof on the party requesting the SOAH hearing in medical fee dispute cases. In part, this comes from the recognition that the party requesting the SOAH hearing is the party seeking to change the status quo established by the MRD Decision.

Carriers argue that there is no status quo once a SOAH hearing is requested, because the MRD Decision is allegedly vacated at that point. That is inaccurate. SOAH cases are routinely dismissed for various reasons and, in such cases, it is recognized that the MRD Decision remains

in effect in the absence of an order from SOAH specifically superseding it.[13] Moreover, requiring providers to bear the burden of proof again at SOAH in situations where the Division ordered the carrier to pay additional reimbursement would essentially nullify the entire MRD dispute resolution process.

In medical fee disputes, it is the healthcare provider who generally initiates the proceeding by filing a request for additional payment from the insurance carrier. Thus, if an MRD Decision is of no consequence whatsoever, and the provider must prove its case again in a SOAH hearing, this would give an unfair procedural advantage to carriers by making providers first attempt to gain payment from the carrier, then attempt to gain payment through the MRD process, and then again attempt to gain payment through the SOAH hearing process. Insurance carriers could choose to deny payment at each step along the way with little or no reason to engage in legitimate good-faith efforts to resolve the dispute, while requiring providers to exert considerable effort to get additional payment.

To give meaning to the rules and purposes behind the Division's dispute resolution process, SOAH ALJs have historically seen the MRD process as having three significant impacts: (1) it defines the scope of the dispute; (2) it limits the claims or defenses that may be raised; and (3) it sets the burden of proof in the SOAH proceeding. So, while the ALJs agree that this is a *de novo* proceeding, they only mean that the SOAH hearing is the proceeding of record (*i.e.*, where the evidentiary record is established). Accordingly, the parties may present new evidence at the hearing not previously considered in the Division's dispute resolution process. The MRD process limits claims and defenses. A provider's claims are limited to those upon which the provider timely requested medical fee dispute resolution.[14] A carrier's defenses

[13] In fact, if Carriers were correct that the MRD Decision is vacated upon the request for a SOAH hearing, then Carriers could simply request a hearing and then move to dismiss the case/withdraw the request before the hearing was conducted. In such a scenario, under Carriers' argument, there would be no existing MRD Decision or order by which Carriers would be bound. This is not a tenable position under the law.

[14] Currently, for medical fee disputes filed on or after June 1, 2012, the applicable language governing a provider's request for dispute resolution can be found at 28 Texas Administrative Code § 133.307(c). For medical fee disputes filed from May 25, 2008, through May 31, 2012, the applicable language is codified at 28 Texas Administrative Code § 133.307(c), located at 33 TexReg 3996-3997 (May 16, 2008). For medical fee disputes filed from January 15, 2007, through May 24, 2008, the applicable language is codified at 28 Texas Administrative Code § 133.307(c), located at 31 TexReg 10333-10334 (December 22, 2006). For medical fee disputes filed from January 1, 2003, through January 14, 2007, the applicable language is codified at 28 Texas Administrative Code § 133.307(c)-(g), located at 27 TexReg 12298-12300 (December 27, 2002). For medical fee disputes filed from January 1, 2002, through December 31, 2002, the applicable language is codified at 28 Texas Administrative Code § 133.307(c)-(g), located at 26 TexReg 10965-10966 (December 28, 2001).

are limited to those raised by the carrier prior to the date the Provider filed its request for medical dispute resolution.[15] The status quo, in the absence of a SOAH decision superseding it, is the MRD Decision.

As has been done historically in SOAH hearings over the last decade, the ALJs find it appropriate to place the burden of proof on the party requesting relief from the MRD Decision. In this docket, that party is Renaissance in the 108 cases listed on Attachment A, and is Carriers for the five cases listed on Attachment B.

B. Renaissance's Theories of Reimbursement

Renaissance presented at the hearing on the merits five theories of calculating reimbursement, four of which are closely related. Renaissance obtained from the Division billing data for every hospital outpatient admission in the Texas workers' compensation system from 2002 to 2007. The data set included the Claim Administrator Claim Number, Principal Diagnosis Code, ICD-9 CM Principal Procedure Code, Service Bill From Date (Service Start Date), Service Bill To Date (Service End Date), Total Charge Per Bill, and Total Amount Paid Per Bill.

With this information, Renaissance's expert witness calculated reimbursement based on four different theories of reimbursement. Renaissance argued that a fair and reasonable payment for its services rendered could be determined by reference to:

1. The average amount paid system-wide for all workers' compensation hospital outpatient admissions in Texas with the same Principal Diagnosis Code and Principal Procedure Code in the same year of service;

2. The average amount paid system-wide for all workers' compensation hospital outpatient admissions in Texas with the same Principal Diagnosis Code and Principal Procedure Code in the same year of service, with potential outlier payments removed;

3. The average amount paid system-wide for all workers' compensation hospital outpatient admissions in Texas with the same Principal Diagnosis Code and Principal Procedure Code for the years 2002 through 2007; or

4. The average amount paid system-wide for all workers' compensation hospital outpatient admissions in Texas with the same Principal Diagnosis

[15] A carrier may not raise a defense at MRD or at the SOAH hearing that it failed to raise prior to the date the request for medical dispute resolution was filed. Formerly 28 Texas Administrative Code § 133.307(d)(2)(b), now codified as § 133.307(d)(2)(F).

Code and Principal Procedure Code for the years 2002 through 2007, with potential outlier payments removed.

Renaissance also asserted a final method of calculating reimbursement based on:

5. The methodology from the Hospital Facility Fee Guideline – Outpatient (the Hospital Outpatient Guideline), adopted on March 1, 2008 (after the years at issue in this docket).[16]

In the five cases in this Consolidated Docket where the Division ordered additional reimbursement to be paid to Renaissance, the MRD Decisions are based upon the average amount paid by all workers' compensation insurance carriers in Texas in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute.

C. ALJs' Analysis

Without conceding Renaissance's right to raise new theories of reimbursement at this stage of the proceedings, Carriers point to flaws in the data set and calculations used by Renaissance. These flaws, Carriers contend, cast doubt on the validity of the data set and the average payment amounts generated therefrom, thus making the first four theories of reimbursement untenable. Carriers argue that, because the 2008 Hospital Outpatient Guideline does not apply to years prior to its effective date, Renaissance's fifth theory requires SOAH to engage improperly in rulemaking.

The Division has stated that reimbursement methodologies using billed hospital charges as their basis or that use a percentage of hospital billed charges as their basis do not provide acceptable fair and reasonable reimbursement amounts. This is, in part, based on the perceived bias of a hospital toward inflating its charges and thereby unreasonably increasing its reimbursement. The ALJs note that a reimbursement system based on a non-uniform, inconsistent, and often unexplained carrier payment system may have a perceived opposite bias and unreasonably reduce reimbursement to providers.

[16] 28 Tex. Admin. Code § 134.403.

In the absence of a legally applicable fee guideline, the ALJs are tasked with determining a statutorily compliant methodology for determining fair and reasonable reimbursement for a large number of cases. In their determination, the ALJs seek to reduce or eliminate any perceived upward or downward bias and to incorporate readily available, trusted, and verifiable data from a nationally recognized neutral source.

For the cases in which Renaissance had the burden of proof, the ALJs find that Renaissance's first four theories are less precise than an alternative methodology. It is important to note that the ALJs *do not* opine that the first four theories submitted by Renaissance are inherently unfair and/or unreasonable. Rather, the ALJs acknowledge the potential complications of these approaches. For example, coding mistakes and differences in coding interpretations, which are not uncommon in medical billing data, may skew the data set. Also, small sample sizes and, in some cases, the total absence of data, generate unusable figures.[17]

The ALJs find, however, that they do not need to rely on the first four methodologies presented by Renaissance. The methodology from the Hospital Outpatient Guideline (the Hospital Outpatient Guideline Methodology) is a sufficiently robust and reliable methodology for calculating fair and reasonable reimbursement for a large number of claims arising prior to its effective date. The Division adopted the Hospital Outpatient Guideline by rule in order to comply with Act § 413.011, which requires fair and reasonable reimbursement guidelines.[18] That section of the Act instructs that the reimbursement structure shall be standardized by adoption of "the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services [(CMS)]"[19] as modified by "one or

[17] *See, e.g.*, the calculations submitted by Renaissance in SOAH Docket Nos. 454-11-2503.M4, 454-11-2694.M4, 454-12-5855.M4, and 454-13-1784.M4. In SOAH Docket No. 454-11-2503.M4 there is a single data point in 2003 and no other data points for the period 2002 through 2007. In SOAH Docket Nos. 454-11-2694.M4, 454-12-5855.M4, and 454-13-1784.M4, there are no data points for the period 2002 through 2007.

[18] *See* 33 TexReg 400 (January 11, 2008).

[19] Act § 413.011(a).

more conversion factors or other payment adjustment factors"[20] taking into account economic indicators in health care and the requirements of Act § 413.011(d).[21]

The Hospital Outpatient Guideline is based on nationally-recognized studies. The Division specified that it used published studies and data from a number of sources, including other state systems, to develop the Hospital Outpatient Guideline.[22] The Division also noted the "enormous amount of research" by CMS into "determining facility reimbursements in the Medicare System."[23] By adjusting the Medicare reimbursement methodologies to account for economic indicators, address medical cost containment, and ensure access to care, the Division arrived at a Payment Adjustment Factor (PAF) for outpatient hospital fees of 200%, to be effective March 1, 2008.[24]

Carriers do not dispute that the 200% PAF in the Hospital Outpatient Guideline applies to determine reimbursement amounts after March 1, 2008. Carriers concede that the Hospital Outpatient Guideline was developed by the Division after a thorough, detailed, and reasoned analysis of all of the applicable statutory directives and policy considerations. They also acknowledge that the Division, in developing and implementing the Hospital Outpatient Guideline, used data from the time periods in question in this Consolidated Docket. However, Carriers contend that by adopting this back-tested and accepted methodology, SOAH would be engaged in "super-agency rulemaking" because the ALJs would be applying a rule before its stated effective date.

While Carriers' argument has some traction at first glance, it ignores the fact that SOAH ALJs routinely arrive at a reasoned outcome for a given case by analogy or by comparison to

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[20] Act § 413.011(b).

[21] As discussed above, Act § 413.011(d) requires a reimbursement structure that ensures the quality of medical care; achieves effective medical cost control; prohibits payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf; and considers the increased security of payment afforded by the Act.

[22] *See* 33 TexReg 401-403 (January 11, 2008) [citing the use of Division data, as well as information from the Texas Health Care Information Collection/Center for Health Statistics (THCIC), Milliman Consultants, the Texas Hospital Association (THA), and Ingenix, Inc.]. The Division obtained data sets from THCIC for calendar years 2003, 2004, and 2005.

[23] 33 TexReg 401 (January 11, 2008).

[24] 33 TexReg 401-402 (January 11, 2008).

other cases, especially when no single authority is clearly on point. That process is adjudicative, and does not transform into rulemaking merely because the ALJs find the reasoning behind a later-developed rule or concept persuasive with respect to earlier situations.

Moreover, the Division used 2005 payment data from the Texas workers' compensation system to develop the 200% PAF for the Hospital Outpatient Guideline, to be effective in 2008. The same PAF should be applicable, therefore, at least to cases in the years 2005 to 2007. And for prior years (2002 to 2005), the 200% PAF still can also be used as a multiplier given that the underlying Medicare payment amount (to which the multiplier is applied) is adjusted for the rates and circumstances that applied in those earlier years. All of the required data for the years at issue is available from the Medicare Outpatient Prospective Payment System. The data is both reliable and verifiable, and it is obtainable from a nationally recognized neutral source without a perceived bias.

For the cases in this Consolidated Docket in which Renaissance has the burden of proof, the Hospital Outpatient Guideline Methodology provides a reliable method to calculate a fair and reasonable payment amount for the services at issue. In 29 cases, the fair and reasonable payment amount calculated by application of the Hospital Outpatient Guideline Methodology to the relevant data from the Medicare Outpatient Prospective Payment System results in a payment that is less than what Renaissance actually received from a carrier.[25] In those cases, Renaissance will not receive any additional payment. Because Carriers did not request a hearing in those cases, Renaissance is not legally obligated to refund any portion of the payment. In 79 other cases, Carrier paid less than a fair and reasonable reimbursement, and the respective Carrier is ordered to make the additional payment indicated on Attachment C.[26]

For the five cases in which the ALJs have determined that Carriers bear the burden of proof, Carriers offered no evidence at the hearing. The MRD Decisions found Carriers' reimbursement insufficient and ordered additional payment to Renaissance to achieve a fair and reasonable reimbursement level. Because Carriers failed to meet their burden of proof, Carriers are ordered to make the payments required by the applicable MRD Decisions. Because

[25] Those cases have a $0.00 amount in the column denominated "Additional Reimbursement Owed to Provider" on Attachment C.

[26] In five cases, the evidence indicates the carrier made no payment.

Renaissance did not contest the MRD Decisions in these five cases, Renaissance may not recover reimbursement in excess of that determined by MRD.

In support of this determination, the ALJs make the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. On various dates between the years 2002 and 2007, hospital outpatient procedures and services (the services) were performed at a Renaissance Hospitals (Renaissance) facility for 113 injured workers.

2. The carriers specified on Attachments A and B (Carriers) were the responsible workers' compensation insurers for the respective injured workers.

3. Renaissance billed each Carrier for the services it provided to the injured worker in each case.

4. The responsible Carrier reimbursed Renaissance the amount specified in the column denominated "Carrier Payment" on Attachment C for the services provided to the injured worker in each case.

5. Renaissance requested additional reimbursement in each of the 113 cases, and in each case the responsible Carrier denied the request.

6. Renaissance is in a Chapter 7 bankruptcy proceeding. Pursuant to an August 2010 Bankruptcy Court Order, the automatic stay was lifted to allow the Chapter 7 Bankruptcy Trustee for Renaissance to continue the claims adjudication process regarding workers' compensation receivables on behalf of the debtor's estate.

7. Renaissance timely filed requests for medical fee dispute resolution with the Texas Department of Insurance, Division of Workers' Compensation (Division).

8. The Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision) in each case.

9. In the cases listed on Attachment A, the Division denied Renaissance's request for additional reimbursement. Renaissance timely requested hearings before the State Office of Administrative Hearings (SOAH) to contest the MRD Decisions in these cases.

10. In the cases listed on Attachment B, the Division ordered Carriers to pay additional reimbursement to Renaissance. Carriers timely requested hearings before SOAH to contest the MRD Decisions in these cases.

11. A Notice of Hearing informed the parties of the date, time, and location of the hearing; the matters to be considered; the legal authority under which the hearing would be held; and the statutory provisions applicable to the matters to be considered.

12. On November 21, 2013, the consolidated hearings convened before Administrative Law Judges Howard S. Seitzman and Pratibha J. Shenoy at SOAH's facilities in Austin, Texas. Renaissance was represented by attorney Patrick Hyde. Carriers were represented by attorney Steven M. Tipton. The record closed on February 7, 2014, following the filing of post-hearing briefs.

13. At the time Renaissance provided the services at issue in each case listed on Attachments A and B, there was no fee guideline for the services.

14. The Division adopted a Hospital Facility Fee Guideline – Outpatient (the Hospital Outpatient Guideline), found at 28 Texas Administrative Code § 134.403, to be effective on March 1, 2008.

15. The Hospital Outpatient Guideline was adopted in order to provide fair and reasonable reimbursement for hospital outpatient services.

16. The Hospital Outpatient Guideline is based on nationally-recognized studies, including data from other state systems, and research conducted by the federal Centers for Medicare and Medicaid Services (CMS).

17. Pursuant to the Hospital Outpatient Guideline, the Division adopted a Payment Adjustment Factor (PAF) for outpatient hospital fees of 200%, effective March 1, 2008.

18. The Hospital Outpatient Guideline methodology provides a more accurate and more reliable method for calculating fair and reasonable reimbursement than the other methodologies proffered.

19. For the cases in which the ALJs have determined that Carriers bear the burden of proof, Carriers offered no evidence at the hearing.

V. 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 as required. Tex. Gov't Code §§ 2001.051, .052.

3. The services provided to the injured workers were not covered by a fee guideline issued by the Division, so the services provided by Renaissance were required to be reimbursed by Carriers at a fair and reasonable rate. Tex. Lab. Code § 413.011.

4. In the cases listed on Attachment A, Renaissance had the burden of proving by a preponderance of the evidence that it had not been reimbursed a fair and reasonable amount by Carriers for the services provided.

5. For the cases in which Renaissance has the burden of proof, the methodology from the Hospital Outpatient Guideline (the Hospital Outpatient Guideline Methodology), applied to the relevant payment data from the Medicare Outpatient Prospective Payment System, provides a reliable method to calculate a fair and reasonable payment amount for the services at issue, including for a large number of claims arising prior to the March 1, 2008 effective date of the Hospital Outpatient Guideline.

6. In 29 cases in which Renaissance had the burden of proof, the fair and reasonable reimbursement amount calculated by application of the Hospital Outpatient Guideline Methodology to the relevant data from the Medicare Outpatient Prospective Payment System results in a reimbursement amount that is less than the reimbursement amount Renaissance actually received from Carriers. In those cases, Renaissance will not receive any additional payment. Because Carriers did not request a hearing in those cases, Renaissance is not legally obligated to refund any portion of the payment. These cases are identified by a $0.00 amount in the column denominated "Additional Reimbursement Owed to Provider" on Attachment C.

7. In 79 cases in which Renaissance had the burden of proof, the fair and reasonable reimbursement amount calculated by application of the Hospital Outpatient Guideline Methodology to the relevant data from the Medicare Outpatient Prospective Payment System results in a reimbursement amount that is greater than the reimbursement amount Renaissance actually received from Carriers. In each such case, the responsible Carrier should be ordered to make the additional payment indicated in the column denominated "Additional Reimbursement Owed to Provider" on Attachment C.

8. In the five cases listed on Attachment B, in which the Carrier had the burden of proof, Carriers failed to prove by a preponderance of the evidence that they had already provided a fair and reasonable reimbursement to Renaissance for the services provided and that no additional reimbursement was due. Carriers should be ordered to make the payments required by the applicable MRD Decisions in these cases as set forth in the column denominated "Additional Reimbursement Owed to Provider" on Attachment C.

ORDER

IT IS ORDERED that the respective Carriers shall make payments to Renaissance in the amounts listed for each case in the column denominated "Additional Reimbursement Owed to Provider" on Attachment C to this Decision and Order, together with all interest as required by law.

SIGNED April 4, 2014.

HOWARD S. SEITZMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

ATTACHMENT A
Page 1 of 3
RENAISSANCE HOSPITALS
CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4

SOAH Docket	MR No.	Requestor	Respondent
454-11-2219.M4	06-4669	Renaissance Hospital	Hartford Underwriters Insurance Co.
454-11-2222.M4	04-8754	Renaissance Hospital	Hartford Insurance Co. of the Midwest
454-11-2233.M4	06-4286	Renaissance Hospital	Fidelity & Guaranty Insurance Co.
454-11-2246.M4	06-5290	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2247.M4	05-B383	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2248.M4	05-B361	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2252.M4	05-B382	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2253.M4	05-B366	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2254.M4	05-B379	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2255.M4	05-B318	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2256.M4	05-B317	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2257.M4	04-8732	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2258.M4	06-4375	Renaissance Hospital	American Zurich Insurance Co.
454-11-2259.M4	05-6456	Renaissance Hospital	Zurich American Insurance Co.
454-11-2260.M4	06-3240	Renaissance Hospital	Zurich American Insurance Co.
454-11-2261.M4	06-4527	Renaissance Hospital	Zurich American Insurance Co.
454-11-2262.M4	04-1491	Renaissance Hospital	Zurich American Insurance Co.
454-11-2263.M4	04-8143	Renaissance Hospital	Zurich American Insurance Co.
454-11-2265.M4	06-4675	Renaissance Hospital	Zurich American Insurance Co.
454-11-2266.M4	06-4338	Renaissance Hospital	Zurich American Insurance Co.
454-11-2267.M4	06-2847	Renaissance Hospital	Zurich American Insurance Co.
454-11-2268.M4	05-6440	Renaissance Hospital	Zurich American Insurance Co.
454-11-2270.M4	05-6548	Renaissance Hospital	Zurich American Insurance Co.
454-11-2271.M4	04-0975	Renaissance Hospital	American Zurich Insurance Co.
454-11-2395.M4	06-0109	Renaissance Hospital	Zurich American Insurance Co.
454-11-2396.M4	05-A011	Renaissance Hospital	Zurich American Insurance Co.
454-11-2397.M4	05-1293	Renaissance Hospital	Zurich American Insurance Co.
454-11-2398.M4	05-1405	Renaissance Hospital	Zurich American Insurance Co.
454-11-2399.M4	06-2411	Renaissance Hospital	Zurich American Insurance Co.
454-11-2400.M4	06-4961	Renaissance Hospital	Zurich American Insurance Co.
454-11-2401.M4	04-6974	Renaissance Hospital	Zurich American Insurance Co.
454-11-2406.M4	06-2936	Renaissance Hospital	Fidelity & Guaranty Insurance Co.
454-11-2407.M4	05-B785	Renaissance Hospital	Fidelity & Guaranty Insurance Co.
454-11-2408.M4	06-4345	Renaissance Hospital	Fidelity & Guaranty Insurance Co.
454-11-2412.M4	05-B776	Renaissance Hospital	American Home Assurance Co.
454-11-2415.M4	06-4389	Renaissance Hospital	American Home Assurance Co.
454-11-2433.M4	04-B542	Renaissance Hospital	Employers General Insurance
454-11-2434.M4	04-6944	Renaissance Hospital	Employers General Insurance
454-11-2435.M4	04-7012	Renaissance Hospital	Employers General Insurance

SOAH Docket	MR No.	Requestor	Respondent
454-11-2466.M4	05-8995	Renaissance Hospital	Insurance Co. of the State of PA

ATTACHMENT A
Page 2 of 3
RENAISSANCE HOSPITALS
CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4

SOAH Docket	MR No.	Requestor	Respondent
454-11-2467.M4	05-4045	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2468.M4	05-1614	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2469.M4	04-5344	Renaissance Hospital	Maryland Casualty Co.
454-11-2470.M4	04-0983	Renaissance Hospital	Maryland Casualty Co.
454-11-2474.M4	06-2606	Renaissance Hospital	Old Republic Insurance Co.
454-11-2476.M4	06-4242	Renaissance Hospital	Old Republic Insurance Co.
454-11-2481.M4	04-7087	Renaissance Hospital	Connecticut Indemnity Co.
454-11-2482.M4	06-4279	Renaissance Hospital	Trinity Universal Insurance Co. of Kansas
454-11-2484.M4	06-2722	Renaissance Hospital	Virginia Surety Co. Inc.
454-11-2491.M4	04-3108	Renaissance Hospital	Metropolitan Transit Authority
454-11-2492.M4	04-1580	Renaissance Hospital	Metropolitan Transit Authority
454-11-2493.M4	04-0712	Renaissance Hospital	Metropolitan Transit Authority
454-11-2498.M4	05-9782	Renaissance Hospital	Northern Insurance Co. of New York
454-11-2499.M4	06-4073	Renaissance Hospital	Mitsui Sumitomo Ins. Co. of America
454-11-2500.M4	06-4963	Renaissance Hospital	____
454-11-2501.M4	04-8797	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2503.M4	04-7352	Renaissance Hospital	Great American Alliance Ins. Co.
454-11-2504.M4	06-4374	Renaissance Hospital	Target Corporation
454-11-2519.M4	05-6873	Renaissance Hospital	Arch Insurance Co.
454-11-2521.M4	04-5861	Renaissance Hospital	Gray Insurance Co.
454-11-2524.M4	04-0984	Renaissance Hospital	Maryland Casualty Co.
454-11-2567.M4	04-6216	Renaissance Hospital	Metropolitan Transit Authority
454-11-2693.M4	05-4083	Renaissance Hospital	American Zurich Insurance Co.
454-11-2694.M4	05-4692	Renaissance Hospital	Zurich American Insurance Co.
454-11-2695.M4	05-4588	Renaissance Hospital	Zurich American Insurance Co.
454-11-2696.M4	05-1194	Renaissance Hospital	Zurich American Insurance Co.
454-11-2697.M4	05-1427	Renaissance Hospital	Zurich American Insurance Co.
454-11-2700.M4	05-0923	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2701.M4	05-5321	Renaissance Hospital	Insurance Co. of the State of PA
454-11-2713.M4	06-0817	Renaissance Hospital	Maryland Casualty Co.
454-11-2714.M4	06-0203	Renaissance Hospital	Fidelity & Guaranty Insurance Co.
454-11-2715.M4	06-0206	Renaissance Hospital	Fidelity & Guaranty Insurance Co.
454-11-2722.M4	04-6843	Renaissance Hospital	Metropolitan Transit Authority
454-11-2733.M4	04-6983	Renaissance Hospital	Royal Indemnity Co.
454-11-2743.M4	05-3502	Renaissance Hospital	Trinity Universal Insurance Co.
454-11-2747.M4	05-1193	Renaissance Hospital	Valiant Insurance Co.

454-11-2900.M4	04-0816	Renaissance Hospital.	Zurich American Insurance Co.
454-11-2901.M4	07-1926	Renaissance Hospital	American Home Assurance Co.
454-11-2902.M4	04-0934	Renaissance Hospital	Zurich American Insurance Co.

ATTACHMENT A
Page 3 of 3
RENAISSANCE HOSPITALS
CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4

SOAH Docket	MR No.	Requestor	Respondent
454-11-2903.M4	04-3171	Renaissance Hospital	Zurich American Insurance Co.
454-11-2906.M4	07-1773	Renaissance Hospital	American Zurich Insurance Co.
454-11-2912.M4	04-8900	Renaissance Hospital	Lumbermens Underwriting Alliance
454-11-2914.M4	04-3086	Renaissance Hospital	Zurich American Insurance Co.
454-11-3151.M4	07-1284	Renaissance Hospital	Zurich American Insurance Co.
454-11-3268.M4	04-B059	Renaissance Hospital	___
454-11-3271.M4	05-0992	Renaissance Hospital	Metropolitan Transit Authority
454-11-3336.M4	08-3856	Renaissance Hospital	Twin City Fire Insurance
454-11-3341.M4	04-5931	Renaissance Hospital	Connecticut Indemnity Co.
454-12-5255.M4	08-5445	Renaissance Hospital	Zurich American Insurance Co.
454-12-5322.M4	07-3488	Renaissance Hospital	Hartford Casualty Insurance Co.
454-12-5570.M4	07-6799	Renaissance Hospital	__-
454-12-5855.M4	06-2061	Renaissance Hospital	___
454-12-5944.M4	07-5709	Renaissance Hospital	New Hampshire Insurance Co.
454-12-6118.M4	08-3530	Renaissance Hospital	___
454-12-6120.M4	08-3267	Renaissance Hospital	___
454-12-6454.M4	08-1390	Renaissance Hospital	Gray Insurance Co.
454-12-6455.M4	08-1562	Renaissance Hospital	Gray Insurance Co.
454-12-6456.M4	08-2394	Renaissance Hospital	Old Republic Insurance Co.
454-12-6457.M4	08-2660	Renaissance Hospital	____
454-12-6458.M4	08-5134	Renaissance Hospital	Seabright Insurance Co.
454-12-7676.M4	08-1527	Renaissance Hospital	Zurich American Insurance Co.
454-12-7678.M4	08-1538	Renaissance Hospital	Zurich American Insurance Co.
454-13-1784.M4	04-3884	Renaissance Hospital	Firemans Fund Insur. Co.
454-13-1785.M4	04-5892	Renaissance Hospital	Gray Insurance Co.
454-13-3770.M4	11-1307	Renaissance Hospital	Gray Insurance Co.
454-13-5236.M4	08-3238	Renaissance Hospital	Ace American Insurance Co.
454-14-0686.M4	08-2399	Renaissance Hospital	_____

ATTACHMENT B
Page 1 of 1
RENAISSANCE HOSPITALS
CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4

SOAH Docket	MR No.	Requestor	Respondent
454-12-0505.M4	07-1892	___	Renaissance Hospital
454-12-7837.M4	07-7748	Fidelity & Guaranty Insurance Co.	Renaissance Hospital
454-13-0110.M4	08-0339	Gray Insurance Co.	Renaissance Hospital
454-13-1331.M4	08-1395	Old Republic Insurance Co.	Renaissance Hospital
454-13-1332.M4	08-1887	Old Republic Insurance Co.	Renaissance Hospital

ATTACHMENT C
Page 1 of 4
RENAISSANCE HOSPITALS
CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4

NO.	SOAH Dkt. No.	Maximum Allowable Reimbursement Rate per 28 TEX. ADMIN. CODE § 134.403 Methodology	Carrier Payment	Total Reimbursement Ordered by MRD	Additional Reimbursement Owed to Provider
1	454-11-2219.M4	$1,298.24	$1,118.00	-	$180.24
2	454-11-2222.M4	$233.38	$1,118.00	-	$0.00
3	454-11-2233.M4	$649.12	$900.00	-	$0.00
4	454-11-2246.M4	$649.12	$683.40	-	$0.00
5	454-11-2247.M4	$1,298.59	$1,118.00	-	$180.59
6	454-11-2248.M4	$1,542.21	$1,118.00	-	$424.21
7	454-11-2252.M4	$1,550.21	$1,118.00	-	$432.21
8	454-11-2253.M4	$707.86	$1,118.00	-	$0.00
9	454-11-2254.M4	$951.74	$1,118.00	-	$0.00
10	454-11-2255.M4	$994.22	$1,118.00	-	$0.00
11	454-11-2256.M4	$1,550.21	$1,118.00	-	$432.21
12	454-11-2257.M4	$724.42	$1,118.00	-	$0.00
13	454-11-2258.M4	$1,622.80	$1,694.64	-	$0.00
14	454-11-2259.M4	$1,237.46	$0.00	-	$1,237.46
15	454-11-2260.M4	$2,068.86	$950.46	-	$1,118.40
16	454-11-2261.M4	$1,988.66	$1,454.29	-	$534.37
17	454-11-2262.M4	$214.48	$0.00	-	$214.48
18	454-11-2263.M4	$1,612.88	$2,098.75	-	$0.00
19	454-11-2265.M4	$8,579.03	$2,587.82	-	$5,991.21
20	454-11-2266.M4	$649.12	$826.45	-	$0.00
21	454-11-2267.M4	$649.12	$1,064.48	-	$0.00
22	454-11-2268.M4	$22,567.26	$2,903.12	-	$19,664.14
23	454-11-2270.M4	$3,881.62	$3,305.15	-	$576.47
24	454-11-2271.M4	$566.28	$799.20	-	$0.00
25	454-11-2395.M4	$6,834.30	$4,577.06	-	$2,257.24
26	454-11-2396.M4	$4,769.38	$1,118.00	-	$3,651.38
27	454-11-2397.M4	$1,033.24	$1,248.75	-	$0.00
28	454-11-2398.M4	$1,448.70	$1,275.00	-	$173.70
29	454-11-2399.M4	$7,308.70	$3,629.73	-	$3,678.97
30	454-11-2400.M4	$3,186.42	$1,620.72	-	$1,565.70
31	454-11-2401.M4	$566.28	$1,198.80	-	$0.00
32	454-11-2405.M4	$891.42	$799.20	-	$92.22

NO.	SOAH Dkt. No.	Maximum Allowable Reimbursement Rate per 28 TEX. ADMIN. CODE § 134.403 Methodology	Carrier Payment	Total Reimbursement Ordered by MRD	Additional Reimbursement Owed to Provider
33	454-11-2406.M4	$7,507.38	$5,273.77	-	$2,233.61
34	454-11-2407.M4	$1,550.21	$616.74	-	$933.47

ATTACHMENT C
Page 2 of 4
RENAISSANCE HOSPITALS
CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4

NO.	SOAH Dkt. No.	Maximum Allowable Reimbursement Rate per 28 TEX. ADMIN. CODE § 134.403 Methodology	Carrier Payment	Total Reimbursement Ordered by MRD	Additional Reimbursement Owed to Provider
35	454-11-2408.M4	$995.72	$1,118.00	-	$0.00
36	454-11-2412.M4	$1,033.24	$1,118.00	-	$0.00
37	454-11-2415.M4	$6,465.36	$1,000.00	-	$5,465.36
38	454-11-2433.M4	$14,928.88	$2,713.70	-	$12,215.18
39	454-11-2434.M4	$566.28	$1,118.00	-	$0.00
40	454-11-2435.M4	$566.28	$1,118.00	-	$0.00
41	454-11-2466.M4	$1,549.86	$494.47	-	$1,055.39
42	454-11-2467.M4	$1,856.20	$1,118.00	-	$738.20
43	454-11-2468.M4	$1,856.20	$1,118.00	-	$738.20
44	454-11-2469.M4	$1,649.40	$3,213.60	-	$0.00
45	454-11-2470.M4	$361.98	$399.60	-	$0.00
46	454-11-2474.M4	$3,827.44	$2,236.00	-	$1,591.44
47	454-11-2476.M4	$7,356.32	$2,236.00	-	$5,120.32
48	454-11-2481.M4	$14,522.02	$2,236.00	-	$12,286.02
49	454-11-2482.M4	$4,807.08	$1,100.00	-	$3,707.08
50	454-11-2484.M4	$1,298.24	$2,236.00	-	$0.00
51	454-11-2491.M4	$1,827.36	$753.12	-	$1,074.24
52	454-11-2492.M4	$1,827.36	$716.87	-	$1,110.49
53	454-11-2493.M4	$1,084.38	$832.37	-	$252.01
54	454-11-2498.M4	$1,450.00	$810.65	-	$639.35
55	454-11-2499.M4	$7,326.78	$2,582.94	-	$4,743.84
56	454-11-2500.M4	$4,684.84	$2,236.00	-	$2,448.84
57	454-11-2501.M4	$2,890.06	$1,118.00	-	$1,772.06

58	454-11-2503.M4	$573.66	$532.78	-	$40.88
59	454-11-2504.M4	$3,134.30	$1,100.00	-	$2,034.30
60	454-11-2519.M4	$2,921.80	$2,022.44	-	$899.36
61	454-11-2521.M4	$579.10	$0.00	-	$579.10
62	454-11-2524.M4	$716.22	$399.60	-	$316.62
63	454-11-2567.M4	$1,924.58	$1,617.61	-	$306.97
64	454-11-2693.M4	$1,856.20	$2,081.25	-	$0.00
65	454-11-2694.M4	$1,898.22	$1,118.00	-	$780.22
66	454-11-2695.M4	$1,033.24	$1,665.00	-	$0.00
67	454-11-2696.M4	$345.02	$2,276.25	-	$0.00
68	454-11-2697.M4	$47,280.44	$2,903.13	-	$44,377.31

ATTACHMENT C
Page 3 of 4
RENAISSANCE HOSPITALS
CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4

NO.	SOAH Dkt. No.	Maximum Allowable Reimbursement Rate per 28 TEX. ADMIN. CODE § 134.403 Methodology	Carrier Payment	Total Reimbursement Ordered by MRD	Additional Reimbursement Owed to Provider
69	454-11-2700.M4	$588.02	$1,118.00	-	$0.00
70	454-11-2701.M4	$1,276.96	$1,118.00	-	$158.96
71	454-11-2713.M4	$1,188.06	$1,182.78	-	$5.28
72	454-11-2714.M4	$1,966.62	$1,322.20	-	$644.42
73	454-11-2715.M4	$3,199.30	$900.00	-	$2,299.30
74	454-11-2722.M4	$882.04	$838.97	-	$43.07
75	454-11-2733.M4	$4,225.04	$1,118.00		$3,107.04
76	454-11-2743.M4	$3,114.04	$1,100.00	-	$2,014.04
77	454-11-2747.M4	$885.06	$2,124.91	-	$0.00
78	454-11-2900.M4	$716.22	$399.60	-	$316.62
79	454-11-2901.M4	$4,919.66	$2,713.70	-	$2,205.96
80	454-11-2902.M4	$716.22	$799.20	-	$0.00
81	454-11-2903.M4	$566.28	$1,198.80	-	$0.00
82	454-11-2906.M4	$2,844.74	$2,141.00	-	$703.74
83	454-11-2912.M4	$807.34	$0.00	-	$807.34
84	454-11-2914.M4	$566.28	$799.20	-	$0.00
85	454-11-3151.M4	$4,790.90	$2,955.77	-	$1,835.13
86	454-11-3268.M4	$2,536.22	$1,018.00	-	$1,518.22
87	454-11-3271.M4	$2,890.06	$2,129.19	-	$760.87
88	454-11-3336.M4	$3,041.56	$1,118.00	-	$1,923.56
89	454-11-3341.M4	$37,923.26	$2,981.00	-	$34,942.26

90	454-12-0505.M4	$4,812.16	$2,236.00	$3,599.85	$1,363.85
91	454-12-5255.M4	$3,634.52	$2,004.17	-	$1,630.35
92	454-12-5322.M4	$8,419.40	$1,118.00	-	$7,301.40
93	454-12-5570.M4	$10,162.12	$2,236.00	-	$7,926.12
94	454-12-5855.M4	$4,966.66	$1,618.00	-	$3,348.66
95	454-12-5944.M4	$3,324.12	$0.00	-	$3,324.12
96	454-12-6118.M4	$9,118.70	$4,492.47	-	$4,626.23
97	454-12-6120.M4	$9,104.32	$4,856.45	-	$4,247.87
98	454-12-6454.M4	$6,595.48	$1,336.11	-	$5,259.37
99	454-12-6455.M4	$2,466.78	$1,028.77	-	$1,438.01
100	454-12-6456.M4	$6,478.10	$2,236.00	-	$4,242.10
101	454-12-6457.M4	$10,238.24	$3,985.00	-	$6,253.24
102	454-12-6458.M4	$3,330.84	$988.55	-	$2,342.29

ATTACHMENT C

RENAISSANCE HOSPITALS
CONSOLIDATED SOAH DOCKET NO. 454-11-2417.M4

NO.	SOAH Dkt. No.	Maximum Allowable Reimbursement Rate per 28 TEX. ADMIN. CODE § 134.403 Methodology	Carrier Payment	Total Reimbursement Ordered by MRD	Additional Reimbursement Owed to Provider
103	454-12-7676.M4	$9,122.54	$2,872.08	-	$6,250.46
104	454-12-7678.M4	$12,840.32	$5,868.15	-	$6,972.17
105	454-12-7837.M4	$9,960.84	$1,118.00	$5,016.82	$3,898.82
106	454-13-0110.M4	$6,018.36	$2,544.96	$4,113.57	$1568.61
107	454-13-1331.M4	$3,281.68	$2,236.00	$3,344.00	$1,108.00
108	454-13-1332.M4	$9,962.80	$4,320.50	$6,411.56	$2,091.06
109	454-13-1784.M4	$14,887.42	$1,423.64	-	$13,463.78
110	454-13-1785.M4	$579.10	$333.00	-	$246.10
111	454-13-3770.M4	$930.80	$499.50	-	$431.30
112	454-13-5236.M4	$5,002.16	$2,353.88	-	$2,648.28
113	454-14-0686.M4	$7,353.40	$3,688.71	-	$3,664.69