CONSOLIDATED SOAH DOCKET NO. 454-11-5700.M4 (LEAD DOCKET)
MR NO. _____

VISTA MEDICAL CENTER HOSPITAL,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
v.	§	**OF**
	§	
STATE OFFICE OF RISK	§	
MANAGEMENT,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

This docket consolidated for hearing 23 cases (Consolidated Docket), listed on Attachment A, because they involve the same basic legal issues and evidence. Each case involves hospital outpatient services rendered by Vista Medical Center Hospital, Vista Hospital of Dallas, or Surgery Specialty Hospital of America (collectively "Vista") between 2003 and 2007 to an injured employee covered by the Texas workers' compensation insurance system. The State Office of Risk Management (SORM) is the carrier in the Consolidated Docket.

In each of the 23 cases, Vista filed a request for dispute resolution with the Medical Review Division (MRD) of the Texas Department of Insurance's Division of Workers' Compensation (Division).[1] The Division issued its Medical Fee Dispute Resolution Findings and Decision (MRD Decision) for each case. In each of the cases, the MRD Decision denied Vista's request for additional reimbursement. Vista timely requested a hearing in each case.

On March 31, 2014, Gary W. Elkins and Howard S. Seitzman, two Administrative Law Judges (ALJs) of the State Office of Administrative Hearings (SOAH), convened the consolidated hearings on the merits at SOAH's facilities in Austin, Texas. Attorney David Bragg represented Vista and Assistant General Counsel J. Red Trip represented SORM.

[1] 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.

Jacquelyn Pham appeared as a witness for Vista, and Jennifer Dawson appeared as a witness for SORM. The affidavit and interest calculations of Hemant Khemka, Chief Financial Officer for Dynacq Healthcare, Inc., were admitted by agreement. The record closed on May 16, 2014, after submission of written 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.[2] Vista requested each of the SOAH hearings and has the burden of proof in this Consolidated Docket.

After considering all of the evidence and arguments, the ALJs conclude that: (1) the reimbursement methodology and the reasoning underlying that methodology, derived from the Division's current fee guideline for hospital outpatients, is an appropriate basis to determine fair and reasonable reimbursement; and (2) this methodology generates the most reliable reimbursement calculations. After applying the conceptual scheme underlying the fee guideline—but not the fee guideline itself—to the facts in evidence, the ALJs also conclude that Vista is entitled to relief in the amounts indicated on Attachment B.

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.[3] 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

[2] The parties' dispute centers on the appropriate methodology to be used in determining fair and reasonable reimbursements for a variety of outpatient surgical services. The particular services themselves are pertinent for discussion only insofar as Vista's theory of recovery relies upon a Medicare reimbursement formula dependent on medical/surgical procedure codes. SORM's reimbursement methodology is generic and does not rely upon medical/surgical procedure codes to calculate reimbursement.

[3] Tex. Lab. Code § 401.011(19) and (31).

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.[4]

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."[5] In setting such guidelines, the increased security of payment afforded by the Act must be considered.[6]

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).[7] 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,
> >
> > (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.[8]

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;

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[4] Act § 413.011(d).

[5] *Id*.

[6] *Id*.

[7] 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).

[8] 28 Tex. Admin. Code § 133.1(8).

(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.[9]

III. DISCUSSION

A. Theories of Reimbursement

Vista's theory of reimbursement is the methodology derived from the Hospital Facility Fee Guideline – Outpatient (the Hospital Outpatient Guideline), adopted on March 1, 2008 (after the years at issue in this docket).[10]

SORM adopted the $1,118 surgical per diem payment from the Acute Care Hospital Inpatient Fee Guidelines (ACHIFG)[11] and increased it by 30% to cover unforeseen costs. This resulted in an outpatient surgical rate of $1,453.40. SORM also allowed for carve-outs and implants paid according to the ACHIFG. SORM applied its 130% ACHIFG surgical reimbursement theory uniformly.

B. ALJs' Analysis

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.

The methodology derived from the Hospital Outpatient Guideline (the Derived Methodology) is a sufficiently robust and reliable approach for calculating fair and reasonable reimbursement for a large number of claims arising prior to its effective date. The Division

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[9] 28 Tex. Admin. Code § 134.1(d)(1)-(3). Effective March 1, 2008, it became 28 Texas Administrative Code § 134.1(f)(1)-(3).

[10] 28 Tex. Admin. Code § 134.403.

[11] The ACHIFG was adopted in 1997, *see* 22 TexReg 6264 (July 4, 1997), and formerly codified at 28 Texas Administrative Code § 134.401 (2007), but it has since been repealed. *See* 33 TexReg 5319 (July 4, 2008).

adopted the Hospital Outpatient Guideline by rule in order to comply with Act § 413.011, which requires fair and reasonable reimbursement guidelines.[12] Section 413.011 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)]"[13] as modified by "one or more conversion factors or other payment adjustment factors"[14] taking into account economic indicators in health care and the requirements of Act § 413.011(d).[15]

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.[16] The Division also noted the "enormous amount of research" by CMS into "determining facility reimbursements in the Medicare System."[17] 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% of the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount, to be effective March 1, 2008.[18]

SORM does not dispute that the 200% PAF in the Hospital Outpatient Guideline applies to determine reimbursement amounts after March 1, 2008. It concedes 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. SORM

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

[13] Act § 413.011(a).

[14] Act § 413.011(b).

[15] 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.

[16] *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.

[17] 33 TexReg 401 (January 11, 2008).

[18] 33 TexReg 401-402 (January 11, 2008).

acknowledges that the Division, in developing and implementing the Hospital Outpatient Guideline, used data from the time periods in question in this Consolidated Docket. However, SORM contends that by adopting the Derived Methodology, SOAH would be engaged in "rulemaking" because the ALJs would be applying the Hospital Outpatient Guideline before its stated effective date.

While SORM's 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 other cases, especially when no single authority is clearly on point. That process is adjudicative, and it 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 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.

SORM's outpatient reimbursement methodology relied upon an inpatient reimbursement methodology specifically rejected by the Division as a methodology for outpatient reimbursement.[19] This is not a criticism of SORM. In fact, to its credit, SORM developed and uniformly applied a methodology in the absence of a fee guideline. The question before the ALJs is whether SORM's methodology achieves a fair and reasonable reimbursement for outpatient surgeries.

SORM did not conduct any independent analysis of the Division's ACHIFG and its unadjusted 1997 reimbursement rate. In addition to relying upon the inpatient methodology

[19] 29 TexReg 4199 (April 30, 2004).

subsequently rejected by the Division as a means of gauging reimbursement for outpatient procedures, SORM added a 30% factor to cover unforeseen expenses. The 30% factor for unforeseen expenses was based upon one SORM employee's opinion derived from his experience running a private business. The size and nature of the business is unknown. There is no evidence that his experience involved operating a hospital or other healthcare provider. As SORM's witness candidly admitted on cross-examination, the 30% factor was arbitrary.

While there is a presumption that the 1997 ACHIFG yields a fair and reasonable reimbursement for inpatient surgical procedures, there is no presumption that it yields a fair and reasonable reimbursement for outpatient surgical procedures.[20] The per diem rate of $1,118 used by SORM is static. The Medicare-based Derived Methodology is dynamic and adjusts annually. There is no evidence that the 1997 flat rate, even at 130%, yielded a fair and reasonable reimbursement 6 to 10 years later. In fact, comparing SORM's 1997-based static reimbursement methodology to the Medicare-based and annually adjusted Derived Methodology demonstrates a statistically significant difference in reimbursement. Unlike the surgical procedure specific and Medicare-based Derived Methodology, the SORM methodology was generic and reimbursed all outpatient surgical procedures at the same flat rate. So, unlike the Derived Methodology, the SORM methodology does not incorporate provider specific data.

The ALJs find that while SORM adopted and uniformly applied an outpatient surgical reimbursement methodology, its methodology failed to provide a fair and reasonable reimbursement for the services at issue. For the cases in this Consolidated Docket, the Derived Methodology provides a back-tested, accepted, and reliable method to calculate a fair and reasonable payment amount for the services at issue.

SORM raised several issues with respect to the application of the Derived Methodology to specific cases. Those objections can be sorted into three categories: (1) the addition of Current Procedure Terminology (CPT) code modifiers not included in the request for medical dispute resolution;(2) the addition of outlier amounts not specifically included in the request for

[20] The ALJs emphasize that they are not dealing with the application of a fee guideline to these cases. Rather, in the absence of a fee guideline, they are examining the application of a methodology that yields fair and reasonable reimbursement for outpatient surgical procedures.

medical dispute resolution; and (3) Vista's request for reimbursement using the Derived Methodology is greater than the amount sought in the request for medical dispute resolution.[21]

SORM expressed concern that four cases had CPT code modifiers.[22] It is unclear to the ALJs why the presence or absence of a modifier is of concern to SORM. As previously noted, SORM's reimbursement methodology was generic. As demonstrated by its Explanation of Benefits (EOBs), SORM did not consider and did not alter its outpatient surgical reimbursement based upon the CPT code. However, because the ALJs are applying the Derived Methodology to determine the fair and reasonable reimbursement in this Consolidated Docket, the ALJs examined the evidence in this record to determine the appropriateness of the CPT code modifiers used by Vista.

Modifier 59 used by Vista in SOAH Docket No. 454-11-5700.M4 allowed CPT code 29826, a shoulder arthroscopy/surgery, to be paid as a separate procedure and not be bundled into CPT code 23120, a partial removal of a collar bone. As shown on the April 15, 2003 operative report of Kenneth Berliner, M.D., modifier 59 was submitted with the request for reconsideration, and is not a new addition to the case. In its dispute resolution form DWC 60, Vista billed and requested $5,175 for CPT code 29826 and $5,980 for CPT code 23120. Under its current reimbursement theory, Vista seeks $4,245.35 for CPT code 29826 and $1,704.97 for CPT code 23120.[23] In both instances, Vista is requesting a lesser amount than it sought in its dispute resolution request. The ALJs find Vista's request in SOAH Docket No. 454-11-5700.M4 is proper.

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[21] In several cases, such as SOAH Docket Nos. 454-11-8803.M4 and 454-12-2538.M4, Vista added CPT codes to its Hospital Outpatient Guideline Methodology reimbursement calculation that were not included in its request for medical fee dispute resolution. The CPT code procedures were performed but, for some reason, Vista either did not bill them or did include them in the dispute resolution request. Vista added these unbilled CPT codes to its reimbursement calculation to prevent the billed procedures from going into outlier, but is not seeking reimbursement for these unbilled CPT codes. The ALJs find this is a proper application of the Hospital Outpatient Guideline Methodology.

[22] In SOAH Docket No. 454-11-5700.M4, Vista used modifier 59 for CPT code 29826. Vista used modifier 59 in SOAH Docket No. 454-11-5874.M4 for CPT code 29877. In SOAH Docket No. 454-11-8530.M4, it used modifier 50 for CPT codes 64483 and 64484. In SOAH Docket No. 454-11-8803.M4, it used modifier FB for CPT code 63650.

[23] In addition, without the modifier 59, CPT code 23455, shoulder repair capsule, would be reimbursed at $4,224.28 rather than at $2,112.13.

The modifier 59 used in SOAH Docket No. 454-11-5874.M4 for CPT code 29877, an arthroscopic abrasion chondroplasty of the right patella, allows for separate reimbursement of CPT code 29880, an arthroscopic resection of torn medial and right lateral menisci. Both CPT codes are specified in the "Diagnosis/Procedures Validation" form and the June 19, 2003 operative report of Willam F. Donovan, M.D. Both forms were submitted to SORM in Vista's request for reconsideration. On the "Diagnosis/Procedures Validation" form adjacent to the CPT code is the corresponding ICD-9 procedure code.[24] For CPT code 29880, the ICD-9 code is 80.6, and for CPT code 29877, the ICD-9 code is 80.86. Both of those ICD-9 codes were denominated in boxes 80 and 81 of the UB-92 provided to SORM prior to Vista's request for medical dispute resolution. Vista's request in SOAH Docket No. 454-11-5874.M4 is proper.

In SOAH Docket No. 454-11-8530.M4, the modifier 50 used for CPT codes 64483 and 64484 indicates a bilateral procedure allowing CPT code 64483, a spinal canal injection, to be reimbursed at 150%, and CPT code 64484, an epidural injection "add-on," to be reimbursed at an effective reimbursement rate of 75%.[25] The respective corresponding ICD-9 codes are 03.91/03.92 and 99.23/99.29. Both 03.91 and 99.29 were denominated in boxes 80 and 81 of the UB-92 provided to SORM prior to the request for medical dispute resolution. The ALJs find Vista's request in SOAH Docket No. 454-11-8530.M4 is proper.

In SOAH Docket No. 454-11-8803.M4, the modifier FB for CPT code 63650 indicates that Vista did not incur a cost for the implantables. The modifier reduces the facility's reimbursement. The ALJs find Vista's request in SOAH Docket No. 454-11-8803.M4 is proper.

SORM contended Vista was prohibited from seeking reimbursements for outlier amounts if the reimbursement was not specifically denominated as an outlier in the request for medical dispute resolution. The ALJs do not reach that specific question because they are not applying the rule set forth in the Hospital Outpatient Guideline. Rather, the ALJs are applying the methodology described in that rule to determine the fair and reasonable reimbursement in this

[24] International Classification of Diseases, Ninth Revision. Unless otherwise noted, all ICD-9 references are to procedure codes as opposed to diagnosis codes.

[25] The procedure was a transforaminal lumbar epidural block at multiple levels with separate puncture sites. The procedure was performed by a surgeon working with an anesthesiologist. With the modifier, the procedure can be billed at 150% of 50%. This yields an effective reimbursement rate of 75%.

Consolidated Docket based upon the evidence contained in this record. As the Derived Methodology considers outlier amounts for reimbursement determinations, the ALJs find the outlier component is an essential component of the methodology. SORM was not precluded from, and had the opportunity to, cross-examine Vista witness Jacquelyn Pham and challenge her calculations. Likewise, SORM had the opportunity to present testimony from its witness, Jennifer Dawson, challenging the computations and to present its own calculations. SORM did neither.

SORM challenged Vista's reimbursement request where the request sought reimbursement greater than the amount sought in the request for medical fee dispute resolution. SOAH ALJs have long held that the provider's DWC 60, absent a mathematical error, sets the ceiling on the reimbursement that can be awarded. If a provider omits an entry or submits an entry in its request for medical dispute resolution that is less than it would otherwise be entitled to, it has essentially waived its right to that sum. SORM raised this issue in SOAH Docket Nos. 454-12-2598.M4 and 454-12-2535.M4.

The DWC 60 Vista filed in SOAH Docket No. 454-12-2598.M4 requested $64 for CPT code 94762, blood oxygen monitoring. At the hearing on the merits in the Consolidated Docket, Vista requested $127 for CPT code 94762. Vista's reimbursement for that CPT code is self-limited to $64.

In SOAH Docket No. 454-12-2535.M4, Vista seeks reimbursement for a variety of CPT codes, including a number of CPT codes paid under Medicare's lab fee schedule. Where the reimbursement requested at the hearing exceeds the reimbursement requested in the request for medical dispute resolution, Vista will be limited to the amount of reimbursement it requested in the DWC 60. In SOAH Docket No. 454-12-2535.M4, the ALJs reduce Vista's reimbursement by $4.80. The following table shows the amount of reimbursement Vista requested in its DWC 60 and the amount of reimbursement Vista requested at the hearing for those CPT codes paid under Medicare's lab fee schedule:

CPT code	Requested Reimbursement in DWC 60	Requested Reimbursement at Hearing	Amount Hearing Reimbursement Request Exceeds DWC 60 Reimbursement Request

80048	$114.45	$14.79	-0-
81002	$3.00	$4.46	$1.46
85025	$14.00	$13.57	-0-
85610	$5.00	$6.86	$1.86
85730	$9.00	$10.48	$1.48
Total			$4.80

In 23 cases, the fair and reasonable payment amount calculated by application of the Derived Methodology to the relevant data from the Medicare Outpatient Prospective Payment System results in a reimbursement amount that is greater than the payment Vista actually received from SORM. Because SORM paid less than a fair and reasonable reimbursement, it is ordered to make the additional payment indicated on Attachment B.

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

IV. FINDINGS OF FACT

1. On dates between 2003 and 2007, various hospital outpatient procedures and services (the services) were performed at Vista Medical Center Hospital, Vista Hospital of Dallas, and Surgery Specialty Hospital of America (collectively "Vista") for injured workers.

2. The State Office of Risk Management (SORM) is the carrier in each of the 23 cases specified on Attachment A and consolidated into this docket (Consolidated Docket).

3. Vista billed SORM for the services it provided to the injured worker in each case.

4. SORM reimbursed Vista the amount specified in the column denominated "Carrier Payment" on Attachment B for the services provided to the injured worker in each case.

5. Vista requested additional reimbursement in each of the 23 cases, and in each case SORM denied the request.

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

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

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

9. 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.

10. On March 31, 2014, the hearings in the Consolidated Docket convened before SOAH Administrative Law Judges (ALJs) Gary W. Elkins and Howard S. Seitzman at SOAH's facilities in Austin, Texas. Attorney David Bragg represented Vista, and Assistant General Counsel J. Red Trip represented SORM. The record closed on May 16, 2014, after submission of written briefs.

11. At the time Vista provided the services at issue in each case listed on Attachment A, there was no fee guideline for the services.

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

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

14. 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).

15. All of the data necessary for computing reimbursement 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.

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

17. The methodology derived from the Medicare-based Hospital Outpatient Guideline (Derived Methodology) is dynamic and adjusts annually. It is surgical procedure specific and incorporates provider specific data.

18. The SORM methodology is based upon a 1997 inpatient reimbursement formula with an arbitrary 30% upward adjustment. The SORM methodology is static to 1997 and is generic in that it does not incorporate either the particular surgical procedure or provider specific data into its reimbursement calculation.

19. SORM's methodology failed to provide a fair and reasonable reimbursement for the services at issue in this Consolidated Docket.

20. The Derived Methodology provides a more accurate and more reliable method for calculating fair and reasonable reimbursement than the methodology proffered by SORM.

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 Vista were required to be reimbursed by SORM at a fair and reasonable rate. Tex. Lab. Code § 413.011.

4. In this Consolidated Docket, Vista had the burden of proving by a preponderance of the evidence that it had not been reimbursed a fair and reasonable amount by SORM for the services provided.

5. For the cases in this Consolidated Docket, the Derived Methodology, when 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.

6. In the 23 cases in this Consolidated Docket, the fair and reasonable reimbursement amount calculated by application of the Derived Methodology to the relevant data from the Medicare Outpatient Prospective Payment System results in a reimbursement amount that is greater than the reimbursement Vista actually received from SORM. In each case, SORM should be ordered to make the additional payment indicated in the column denominated "Additional Reimbursement Owed to Provider" on Attachment B.

ORDER

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

SIGNED June 26, 2014.

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

GARY W. ELKINS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

ATTACHMENT A
CONSOLIDATED SOAH DOCKET NO. 454-11-5700.M4

SOAH Docket	MR No.	Requestor	Respondent
454-11-5700.M4	04-6203	Vista Medical Center Hospital	State Office of Risk Management
454-11-5874.M4	04-6365	Vista Medical Center Hospital	State Office of Risk Management
454-11-6065.M4	05-0984	Vista Medical Center Hospital	State Office of Risk Management
454-11-6989.M4	04-B029	Vista Medical Center Hospital	State Office of Risk Management
454-11-6994.M4	05-2164	Vista Medical Center Hospital	State Office of Risk Management
454-11-7601.M4	06-0362	Vista Medical Center Hospital	State Office of Risk Management
454-11-7726.M4	05-5253	Vista Medical Center Hospital	State Office of Risk Management
454-11-7799.M4	05-8457	Vista Medical Center Hospital	State Office of Risk Management
454-11-7971.M4	06-3460	Vista Hospital of Dallas	State Office of Risk Management
454-11-8491.M4	06-5044	Vista Medical Center Hospital	State Office of Risk Management
454-11-8530.M4	06-5164	Vista Medical Center Hospital	State Office of Risk Management
454-11-8560.M4	06-3475	Vista Hospital of Dallas	State Office of Risk Management
454-11-8622.M4	06-2306	Vista Hospital of Dallas	State Office of Risk Management
454-11-8627.M4	06-2208	Vista Hospital of Dallas	State Office of Risk Management
454-11-8803.M4	06-0922	Vista Medical Center Hospital	State Office of Risk Management
454-12-0436.M4	07-4358	Vista Medical Center Hospital	State Office of Risk Management
454-12-1995.M4	07-7179	Vista Medical Center Hospital	State Office of Risk Management
454-12-2527.M4	09-3981	Surgery Specialty Hospital of America	State Office of Risk Management
454-12-2537.M4	08-1906	Vista Medical Center Hospital	State Office of Risk Management
454-12-2538.M4	08-2755	Vista Medical Center Hospital	State Office of Risk Management
454-12-2598.M4	08-1568	Vista Hospital of Dallas	State Office of Risk Management
454-12-2623.M4	08-6622	Surgery Specialty Hospital of America	State Office of Risk Management
454-13-2535.M4	07-1837	Vista Medical Center Hospital	State Office of Risk Management

ATTACHMENT B
CONSOLIDATED SOAH DOCKET NO. 454-11-5700.M4

#	SOAH Dkt. No.	Fair and Reasonable Reimbursement per 28 Tex. Admin. Code § 134.403 Derived Methodology	Carrier Payment	Reimbursement Adjustments by ALJs	Additional Reimbursement Owed to Provider
1	454-11-5700.M4	$8,062.45	$1,453.40		$6,609.05
2	454-11-5874.M4	$4,060.60	$1,453.40		$2,607.20
3	454-11-6065.M4	$1,476.76	$1,453.40		$23.36
4	454-11-6989.M4	$2,958.20	$1,453.40		$1,504.80
5	454-11-6994.M4	$1,474.64	$1,453.40		$21.24
6	454-11-7601.M4	$2,102.64	$1,453.40		$649.24
7	454-11-7726.M4	$1,617.62	$1,453.40		$164.22
8	454-11-7799.M4	$1,555.96	$1,453.40		$102.56
9	454-11-7971.M4	$2,167.14	$1,453.40		$713.74
10	454-11-8491.M4	$6,534.90	$1,453.40		$5,081.50
11	454-11-8530.M4	$2,405.27	$1,453.40		$951.87
12	454-11-8560.M4	$2,221.51	$1,453.40		$768.11
13	454-11-8622.M4	$5,090.40	$1,453.40		$3,637.00
14	454-11-8627.M4	$2,472.38	$1,453.40		$1,018.98
15	454-11-8803.M4	$2,413.70	$1,453.40		$960.30
16	454-12-0436.M4	$2,064.85	$1,453.40		$611.45
17	454-12-1995.M4	$2,204.72	$1,453.40		$751.32
18	454-12-2527.M4	$2,030.65	$1,453.40		$577.25
19	454-12-2537.M4	$11,299.16	$6,711.40		$4,587.76
20	454-12-2538.M4	$5,625.47	$1,453.40		$4,172.07
21	454-12-2598.M4	$3,641.91	$1,453.40	($64.00)	$2,124.51
22	454-12-2623.M4	$2,026.46	$1,453.40		$573.06
23	454-12-2535.M4	$3,882.24	$1,453.40	($4.80)	$2,424.04