MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address The San Antonio Orthopaedic Surgery Center PO Box 34533 San Antonio, Texas 78265	MDR Tracking No.: M4050013-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Insurance Company of the State of PA Flahive, Ogden & Latson, Box 19	Date of Injury: Employer's Name: United Airlines Corporation Insurance Carrier's No.: 016777148366WC01

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
10/21/2003	**10/21/2003**	**29881 – Arthroscopic medial meniscectomy**	**$11,100.00**	**$0.00**
10/21/2003	**10/21/2003**	**29877 – Chondroplasty**		

PART III: REQUESTOR'S POSITION SUMMARY

The carrier has not provided the proper payment exception code. The carrier did not make fair and reasonable reimbursement. The carrier did not provide any documentation of a developed or consistently applied methodology, which was used in reducing payment for the treatment/service in question. The carrier failed to provide an adequate response to the request for reconsideration and it is the provider's position that the carrier is required to pay the entire amount in dispute.

PART IV: RESPONDENT'S POSITION SUMMARY

The billing in dispute has been paid at a fair and reasonable rate. The carrier has paid $2,236.00, which represents an amount equal to or greater than the fair and reasonable reimbursement for these services. The carrier calculated the reimbursement based upon the inpatient hospital fee guides for surgical care and issued payment based on two days of inpatient care, even though this was just a partial day of outpatient services. The provider's position on the requested reimbursement amount is not credible.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that neither the requestor nor the respondent provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). The failure to provide persuasive information that supports their proposed amounts makes rendering a decision difficult. While the requestor's requested amount appears inflated, the respondent methodology was based on an inpatient reimbursement amount and could not, without further consideration, be readily adopted as the appropriate reimbursement. After reviewing the services, the charges, and both parties' positions, it appeared that some other amount might represent the fair and reasonable reimbursement.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities (from 192.6% to 256.3% of Medicare for this particular year).

In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not binding in nature, the ranges and information developed in this process provided a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study. Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. In making this comparison, it appeared that the insurance carrier's total payment is almost identical to the reimbursement that we would order if we considered ordering near the middle of the Ingenix range. Given the nature of the procedure and the documentation in the file, this amount does appear to be a "fair and reasonable" amount for reimbursement. This amount was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommended amount, discussed the facts of the individual case, and selected this amount as the appropriate "fair and reasonable" amount to be ordered in the final decision.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that the fair and reasonable reimbursement amount for these services is $2,236.00. No additional reimbursement is due.

PART VII: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Issued by:

Authorized Signature	Allen C. McDonald, Jr.	April 27, 2005
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _04/27/2005_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____