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 TX 78265-4533	MDR Tracking No.: M4-05-0017-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX: 22 Fidelity & Deposit Co. of Maryland	Date of Injury: Employer's Name: Texas General Agency, Inc Insurance Carrier's No.: 743023948LBM

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4/26/04	4/26/04	64721 RT	4,261.50	$950.00
			IC Paid	(-$557.50)
			Additional Reimb. DUE:	$392.50

PART III: REQUESTOR'S POSITION SUMMARY

The insurance carrier has not provided the proper payment exception code in this instance, and is obligated to pay fair and reasonable compensation in accordance with §413.011 of the Texas Labor Code and Commission Rule 133.304. Carrier did not make "fair and reasonable" reimbursement and did not make consistent reimbursements.

PART IV: RESPONDENT'S POSITION SUMMARY

Zurich Insurance Group has provided EOB's with an indication that the procedure was paid at 125% of the Medicare ASC Group 2 rate.

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.

Claimant underwent the following procedure(s): . Based upon anesthesia report, the procedure took 1 hour and 10 minutes to complete.

After reviewing the documentation provided by both parties, it appears that neither party has provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). After reviewing the services, the charges, and both parties' positions, it is clearly evident that some other amount represents 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. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides 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 from 213.3% - 290.% of Medicare for year 2004. Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review and considering the similarity of the various procedures involved in this surgery, staff selected a reimbursement amount in the lower of the Ingenix range. The total 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 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 $950.00. Since the insurance carrier paid a total of $557.50 for these services, the health care provider is entitled to an additional reimbursement in the amount of $392.50.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $392.50. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

		7 / 13 / 05
Authorized Signature	Name	Date of Order

PART VII: 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 _____. 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 VIII: 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: _____