

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor  The San Antonio Orthopaedic Surgery Center P.O. Box 34533 San Antonio, TX 78625	MDR Tracking No.: M4-05-0079-01
	TWCC No.:
	Injured Employee's Name:
Respondent  American Home Assurance Company P.O. Box 13367 Austin, TX 78711	Date of Injury:
	Employer's Name: Temple Inland Inc.
	Insurance Carrier's No.: 35932901893507

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/25/04	03/25/04	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) (code 29881)	\$5,893.36	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

The insurance carrier has not provided the proper payment exception code in this instance, which is in violation of the Texas Administrative code. The insurance carrier did not make "fair and reasonable" reimbursement and did not make consistent reimbursements.

## PART IV: RESPONDENT'S POSITION SUMMARY

Lacking an established fee guideline (MAR) for outpatient procedures, the insurance carrier used payment exception code "M" and provided a reimbursement amount of \$1,882.64. The insurance carrier did not provide a response to this dispute and methodology for reimbursement is therefore unknown.

## 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 Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) (code 29881). Based upon anesthesia report, the procedure took 36 minutes to perform.

The insurance carrier paid \$1882.64.

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% to 290% of Medicare for 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 low end of the Ingenix range. Based on this review, the original reimbursement on these services exceeds the Ingenix range. The decision for no additional reimbursement was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the decision and discussed the facts of the individual case.

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 no additional reimbursement is due for these services.

**PART VI: 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.

Findings and Decision by:

Elizabeth Pickle, RHIA

June 29, 2005

Authorized Signature

Typed 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 19. 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 en 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 in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_