Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Surgical and Diagnostic Center, LP 729 Euless Road West, Ste. 100 Hurst, TX 76053	MDR Tracking No.: M4-05-0116-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Continental Casualty Co. C/o Stone, Loughlin & Swanson, LLP Box 06	Date of Injury: Employer's Name: Wesco Valve & Mfg. Co., Inc. Insurance Carrier's No.: 64825558

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's Position Summary states in part, "…Surgical and Diagnostic Center contends that the fee paid was not fair and reasonable because it is below the amount of the majority of other insurance carriers are reimbursing and does not take into account all of the supplies and medications to treat this patient, the amount of time spent in the procedure room/operating room, and other cots. The fee paid does not ensure the quality of medical care because we were not adequately reimbursed for the combination of items that was used for this patient. The fee paid does not ensure effective medical cost control because it does not properly compensate for items specifically needed by and provided to the patient.

Principle Documentation:
1. TWCC-60
2. Operative Report
3. EOBs
4. UB-92

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent's Position Summary states in part, "…Carrier's rate of reimbursement in this case for both dates of service is consistent with the Act's criteria for payment. Provider has the burden of proof in this case. As stated by the MRD in prior ASC disputes, regardless of the carrier's application of its methodology, lack of methodology, or response, the burden is on the provider to show that the amount of reimbursement request is fair and are reasonable…"

Principle Documentation:
1. TWCC-60 Response
2. Position Summary
3. EOB
4. Update of Rates & Wage Index for ASC Payments
5. Nevada Fee Schedule
6. Rates for Services Under M.G.L.
7. Pennsylvania Medical Fee Review Section
8. SOAH Decisions
9. MDR Decision

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
09/23/03	Ambulatory Surgical Center Care	1	$0.00
12/02/03	Ambulatory Surgical Center Care	1	$51.32
		Total Due:	$51.32

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

1. 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 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 192.6% to 256.3% of Medicare for 2003). 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 both surgeries for dates of service 09/23/03 and 12/02/03, staff selected a reimbursement amount within the Ingenix range for date of service 9/23/03 and selected a reimbursement amount in the lower end of the Ingenix range for date of service 12/02/03. The decision for no additional reimbursement for date of service 09/23/03 and the total amount to be reimbursed for date of service 12/02/03 were 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 date of service 12/02/03 is $951.33. Since the insurance carrier paid a total of $900.00 for these services, the health care provider is entitled to an additional reimbursement in the amount of $51.32.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.1
28 Texas Administrative Code Sec. 133.307

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of $51.32. 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 30-days of receipt of this Order.

Ordered by:

	Marguerite Foster	October 28, 2005
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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