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 San Antonio Orthopaedic Surgery Center P.O. Box 34533 San Antonio, TX 78265	MDR Tracking No.: M4-05-0596-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Insurance Company c/o Flahive, Ogden & Latson 505 West 12th Street Austin, TX 78701	Date of Injury: Employer's Name: Jupe Company DVR Insurance Carrier's No.: 2720000969

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04-26-04	04-26-04	29827 – Anthroscopy, shoulder	7,701.13	83.12
04-26-04	04-26-04	29824 – removal of foreign body	7,292.13	684.38
04-26-04	04-26-04	29823 – debridement	7,292.12	-0-
04-26-04	04-26-04	29826 - decompression	7,292.12	-0-
			Total Amount Due:	767.50

PART III: REQUESTOR'S POSITION SUMMARY

The insurance carrier paid the provider based on the "M" payment exception code of "no MAR." Texas Administrative Code Section 133.304 directs that the explanation of benefits shall include the correct payment exception code required by the Commission. The provider states that the carrier has not provided the proper payment exception code in this instance and requests proper reimbursement for the treatment and/or services rendered.

PART IV: RESPONDENT'S POSITION SUMMARY

The insurance carrier states that the amount of $3,127.50 paid to the provider represents fair and reasonable in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. The carrier calculated the reimbursement based upon 125% of the applicable Medicare reimbursement for the services performed. The provider must prove that the reimbursement received is not fair and reasonable. The carrier requests a refund of any amount previously paid in excess of the rate determined to be fair and reasonable.

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 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 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 medium part of the Ingenix range. In addition, the reimbursement for the secondary procedures were reduced by 50% consistent with standard reimbursement approaches. 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 $3,895.00. Since the insurance carrier paid a total of $3,127.50 for these services, the health care provider is entitled to an additional reimbursement in the amount of $767.50.

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 $767.50. 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.

Finding and Decision by:

		07/19/05
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 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: _____