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	MDR Tracking No.: M4050602-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Cunningham Lindsey Box 11	Date of Injury: Employer's Name: Christus Santa Rosa Insurance Carrier's No.: 22800006523

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/28/2004	04/28/2004	Lumbar Epidural Steroid Injection	$1,063.43	$0

PART III: REQUESTOR'S POSITION SUMMARY

The carrier has not provided the proper payment exception code in this instance, which is in violation of the Texas Administrative Code. Under section 413.011 and Commission rule 133.304 the carrier is obligated to pay fair and reasonable compensation. The respondent failed to show that the payment made is fair and reasonable. The carrier did not document its methodology and did not make consistent reimbursement.

PART IV: RESPONDENT'S POSITION SUMMARY

The carrier's determination of fair and reasonable meets all the standards in the Texas Labor Code and the TWCC Rules. The health care provider has not met its burden of proof to establish that its charges and the reimbursement it seeks is fair and reasonable, and comply with Section 413.011(b) of the Texas Labor Code and commission rules. The carrier has developed and consistently applied a methodology for reimbursing ASC services.

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 the respondent provided persuasive information that supports that their recommended amount is fair and reasonable. It does not appear that the requestor provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307).

The insurance carrier considered the reimbursement rate for hospitals for the same type of procedure. It is important to note that the procedure was a lumbar facet injection and the provider has not explained any realistic rationale to support the charged amount for such a very limited intervention. Lastly, researching the amounts paid for the facility charge for the same service in other health care systems appears to support the amount paid

by the insurance carrier, and not the amount charged by the provider. Simply stated, the carrier's position appears more credible.

Based on the documentation contained in this dispute and both parties' positions, no additional payment is due.

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.

Ordered by:

	Allen C. McDonald, Jr.	04/27/2005
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 on __4/27/2005__. 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, Mail Stop 35, 7551 Metro Center Dr., Suite 100, 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: ____________________