MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	
Requestor's Name and Address Surgical and Diagnostic Center, LP 729 Bedford-Euless Road West, Suite 100 Hurst, TX 76053	MDR Tracking No.: M4-05-0614-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Insurance Company **Box 19** P.O. Box 4996 Syracuse, NW 13221	Date of Injury: Employer's Name: Lear Company Insurance Carrier's No.: YBUC 31275

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/16/03	10/16/03	77.83 (25350)	$3,387.88	$1,001.52
10/16/03	10/16/03	81.96 (29901)		$500.76
10/16/03	10/16/03	Implant	$1,311.88	$429.00
10/16/03	10/16/03	80051	$44.00	$0.00
10/16/03	10/16/03	93005	$35.00	$0.00
10/16/03	10/16/03	93010	$15.00	$0.00
			IC Paid:	($1,118.00)
			Total Amount Due:	$813.28

PART III: REQUESTOR'S POSITION SUMMARY

Our charges are fair and reasonable based on other insurance companies' determination of fair and reasonable payment of 85% - 100% or our billed charges. Workers' compensation carriers are subject to a duty of good faith and fair dealings in the process of workers' compensation claims. Also requesting reimbursement for implants at cost plus 10%, and reimbursement for lab work and diagnostic testing.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent believes that the requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the Act and is not entitle to additional reimbursement.

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 the requestor nor the respondent provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). The failure to provide persuasive information that supports their proposed amounts makes rendering a decision difficult. While the requestor's requested amount appears inflated, the respondent's recommended amount appears deficient. After reviewing the services, the charges, and both parties' positions, it is clearly evident that some other amount represents the fair and reasonable reimbursement.

Prior to December 2004, Medical Dispute Resolution approached this type of review heavily from a "burden of proof" perspective. Unfortunately, this type of approach generally resulted in an "all or nothing" orders, which may not have been "fair" to either party. Accordingly, a new approach or methodology had to be established.

The primary driver of Medical Dispute Resolution actions is our role in resolving these fee disputes. Pursuant to Texas Labor Code §413.031(b), our role in these cases is to adjudicate the "payment" given the provisions of the Act and rules. We must determine the reimbursement payment amount that should be ordered for a particular dispute, not just weigh "burden of proof" arguments.

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 (from 192.6% to 256.3% of Medicare for this particular year - 2003). In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not binding in nature, the ranges and information developed in this process provided 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 procedure in this case to the amount that would be within the reimbursement range recommended by the Ingenix study. 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, staff selected a reimbursement amount in the low end of the Ingenix range, plus the cost of implantables and 10%. Furthermore, according to CMS ASC guidelines, lab fees and diagnostic or therapeutic items or services are included in the facility fees and not separately payable. 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 are $1,931.28, less the $1,118.00 already paid by the insurance carrier.

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 $813.28. 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:

	Marguerite Foster	August 11, 2005
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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: _____