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.: M4-05-0833 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Dallas Fire Insurance Co. Box: 17 c/o Downs-Stanford, P.C. 2001 Bryan St. Suite 4000 Dallas, TX 75201	Date of Injury: Employer's Name: Smith Mobley Inc. Insurance Carrier's No.: 99D0000359431

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
12/15/03	12/15/03	CPT Code 29824 – Shoulder Arthroscopy	$6,156.00	$522.73
12/15/03	12/15/03	CPT Code 29823-59 – Shoulder Arthroscopy	$7,274.00	$583.00
12/15/03	12/15/03	CPT Code 29826– Shoulder Arthroscopy	$7,274.00	$583.00
12/15/03	12/15/03	CPT Code 29807– Shoulder Arthroscopy	$7,274.00	$583.00
12/15/03	12/15/03	H99070 – Implantables	$252.00	$231.00
			Total Amount Due:	**$2,502.00**

PART III: REQUESTOR'S POSITION SUMMARY

The Carrier, DALLAS FIRE INSURANCE, denied payment with payment exception code(s) "No Payment Exception Code" on the explanation of benefits… The Carrier failed to provide an adequate response to the request for reconsideration. Based upon the initial denial presented by the Carrier, it is the requestor's position that the Carrier is required to pay the entire amount in dispute…

PART IV: RESPONDENT'S POSITION SUMMARY

A fair and reasonable reimbursement, if any, would be the amount determined in accordance with application of factors set out in Section 413.011. In this case, payment would be based upon what would be paid for the same procedure should the services be rendered at an inpatient facility. Applicability of the per diem amount is appropriate…

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.

According to the operative report the procedures performed were a left shoulder arthroscopic-assisted extensive debridement of the labrum and the rotator cuff; subacromial decompression; distal clavicle resection; and repair of the Bankart lesion using the Arthrex anchor bio-absorabable.

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 this surgery, staff selected a reimbursement amount in 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, including implantables, is $3,620.00. Since the insurance carrier paid a total of $1,118.00 for these services, the health care provider is entitled to an additional reimbursement in the amount of $2,502.00.

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 $2,502.00. 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:

	James Schneider	July 7, 2005
Authorized Signature	Typed Name	Date of Order

Decision Rendered by:

	Marguerite Foster	July 7, 2005
Authorized Signature	Typed Name	Date of Decision

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: ________________________