MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor The San Antonio Orthopaedic Surgery Center P.O. Box 34533 San Antonio, TX 78625	MDR Tracking No.: M4-05-0839-01 TWCC No.: Injured Employee's Name:
Respondent Old Republic Insurance Co. Rep. Box # 2	Date of Injury: Employer's Name: Levi Strauss & Co. Insurance Carrier's No.: 35961356521383

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07-19-04	07-19-04	Codes: 25210, 20526, 20600, and 20600	$4,013.03	$0.00
		Insurance carrier's payment (subtracted)		($1,669.97)
		Total Amount Due		$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The insurance carrier did not provide the proper payment exception code in these instances, which is in violation of the Texas Administrative Code. The insurance carrier did not make "fair and reasonable" reimbursement and did not make consistent reimbursements.

PART IV: RESPONDENT'S POSITION SUMMARY

The Requestor has indicated on the TWCC-60 the amount of reimbursement made by the carrier is $1,180.97. However the explanation of benefits indicates the reimbursement actually paid by the carrier is $1,669.97. The recommended allowance of $1,669.97 reflects fair and reasonable reimbursement for the geographic area the service was rendered. A consistent methodology was applied to determine fair and reasonable reimbursement amounts to ensure that similar procedures in similar facilities receive similar reimbursement. The Requestor also indicated the amount billed was $5,194.00. Again, the explanation of benefits (as well as the UB-92) reflects total charges of $5,683.00. The Requestor failed to submit documentation to support the usual and customary charges of $5,683.00 are fair and reasonable for the facility fee billed. The medical record did not reflect any usual circumstances to justify charges in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living.

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.

Claimant underwent excision of pisiform, left wrist (25210), injection of carpal canal with steroids (20526-59), injection of the trigger of the long finger (20600-59), injection of the trigger of the ring finger (20600-59). Based upon anesthesia report, the procedure took 18 minutes to perform.

The insurance carrier paid $1,669.97.

Insurance carrier used payment exception code M which states the allowance made by the carrier is based on reasonable and customary reimbursement for the region in which the services were rendered. Payment exception code M is appropriate for the payment made. The carrier did not make additional payment upon reconsideration and defines the audit rationale and methodology used to determine fair and

reasonable reimbursement. The procedure code 20526 is traditionally included in the reimbursement of the primary procedure, therefore no additional reimbursement is warranted for this injection. Requestor billed for separate joint injections instead of using the appropriate code, which indicates multiple trigger point injections. Reimbursement was made as if the provider has billed the appropriate bundled code.

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% to 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. 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, the original reimbursement on these services is within the low end of the Ingenix range. The decision for no additional reimbursement was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the decision and discussed the facts of the individual case.

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 no additional reimbursement is due for these services.

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.

Findings and Decision by:

	Elizabeth Pickle, RHIA	June 29, 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 19 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: _____