

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC		<b>Response Timely Filed?</b> (X) Yes ( ) No	
Requestor's Name and Address  The San Antonio Orthopaedic Surgery Center P.O. Box 34533 San Antonio, TX 78625		MDR Tracking No.: M4-05-0881-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address <b>BOX 19</b> Zurich American Insurance Company P.O. Box 619507 Dallas, TX 75261		Date of Injury:	
		Employer's Name: American Property Management	
		Insurance Carrier's No.: 2230110819	

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/28/04	05/28/04	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release (code 29826)	\$7,072.75	\$0.00
05/28/04	05/28/04	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure) (code 29824)	\$7,027.75	\$0.00
05/28/04	05/28/04	Arthroscopy, shoulder, surgical; debridement, extensive (code 29823)	\$7,072.75	\$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 insurance carrier's payment is fair and reasonable and in accordance with TWCC guidelines, policies, and the Texas Labor Code. The provider must prove that the reimbursement received is not fair and reasonable. The insurance carrier paid \$3,003.75 for the surgical procedures. The insurance carrier tendered payment based upon the current Medicare Surgery Center rates plus an added 25% co-pay factor, which is based on recent State Office of Administrative Hearings decisions. The requestor's assertion that it is entitled to an additional \$21,218.25 is not credible.

## 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 appeared that some other amount may represent the fair and reasonable reimbursement and additional comparisons were appropriate.

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 this particular year). 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, it appears that the insurance carrier's payment falls in the middle of this range. There was no information provided by the requestor to show that this amount did not represent a "fair and reasonable" reimbursement. Accordingly, staff recommended that the amount paid by the insurance carrier be considered the fair and reasonable reimbursement for this particular situation. 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 \$3,003.75, the amount previously paid by the insurance carrier.

**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:

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 04/27/2005. 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 en 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 in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_