Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Plaza Day Surgery 909 Ninth Ave. Fort Worth, TX 76104	MDR Tracking No.: M4-05-1448-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Co. Box 54	Date of Injury: Employer's Name: Alpha Industries, Inc. Insurance Carrier's No.: 99B0000293319

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor's position summary states "It is my position that my client was not reimbursed at Fair and Reasonable on these bills. My client always bills their Usual and Customary charges and, as such, the amounts paid to my client do not appear to be Fair and Reasonable. They paid a total of $3,966.30 on billed charges of $35,560.00."

Principle Documentation: 1. TWCC-60
2. EOBs
3. UB-92's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

It is this carrier's position that a) the requester failed to produce any evidence that its billing for the disputed procedures is fair and reasonable; b) this carrier's payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; c) Medicare fair and reasonable reimbursement for similar or same facility services is below this carrier's, and d), the Commission has concluded that charges cannot be validated as true indicators of the facility's cost.

Principle Documentation: 1. TWCC-60 response
2. Position Statement
3. ASC Groups

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
01/12/04	Ambulatory Surgical Center Care	1	$0.00
02/16/04	Ambulatory Surgical Center Care	1	$0.00
05/05/04	Ambulatory Surgical Center Care	1	$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1. 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 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. Based on this review, the original reimbursement on these services is within 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: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.1
28 Texas Administrative Code Sec. 133.307

PART VII: DIVISION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Decision by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	December 5, 2005

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.