



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: Surgical and Diagnostic Center, LP 729 Bedford Eules Road West, Suite 100 Hurst, TX 76053	MDR Tracking No.: M4-05-2094-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Zurich American Ins. Co./Rep. Box #: 19	Date of Injury:
	Employer's Name: Wellpoint Health Networks Inc
	Insurance Carrier's No.: 2230106249

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary of November 8, 2004 states, "...Surgical and Diagnostic Center contends that the fee paid was not fair and reasonable because it is below the amount the majority of other insurance carriers are reimbursing and does not take into account all of the supplies and medications to treat this patient, the amount of time spent in the procedure room/operating room, and other costs. The fee paid does not ensure the quality of medical care because we were not adequately reimbursed for the combination of items that was used for this patient. The fee paid does not ensure effective medical cost control because it does not properly compensate for items specifically needed by and provided to the patient..."

Principle Documentation:

1. Table of Disputed Services
2. UB-92
3. Explanation of Benefits
4. Operative Report
5. Anesthesia Report

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Untimely response of December 3, 2004 states, "...The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that \$568.75 represents fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable..."

Principle Documentation:

1. Flahive, Ogden & Latson letter of December 3, 2004

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12-23-03	Ambulatory Surgical Center Care	1	\$304.58

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 192.6% to 256.3% 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 and considering the similarity of the various procedures involved in this surgery, staff selected a reimbursement amount in the low end 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.

Per CMS ASC guidelines CPT code 86701 is bundled into the covered service billed and reimbursement is not recommended.

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 \$873.33. Since the insurance carrier paid a total of \$568.75 for these services, the health care provider is entitled to an additional reimbursement in the amount of \$304.58

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.202(e)(3)

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of \$304.58. 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 30-days of receipt of this Order.

Ordered by:

Roy Lewis

9-8-05

Authorized Signature

Typed Name

Date of Order

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.