



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> ( x ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Plaza Day Surgery Center 909 Ninth Ave. Fort Worth TX 76104	MDR Tracking No.: M4-05-2109-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: BOX#: 3  City of Fort Worth	Date of Injury:
	Employer's Name: City of Fort Worth
	Insurance Carrier's No.: WC0320011781

### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principal documents: 1. UB-92 / EOB's  
2. Table of Disputed Services  
3. Requestor's statement/position

Position Summary: "...It is my position that my client was not reimbursed at Fair and Reasonable on these bills (for ambulatory surgical care). 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. Liberty Mutual paid a total of \$1,118.00 on billed charges of \$32,124.88..."

### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent **did** respond to this medical dispute, but due to a possible miss-filing, the response did not get placed into the file.

Denial Summary taken from the Reconsideration EOB: The 'reconsideration EOB' retained the same denial of reduction of payment as stated on the initial denial. The denial on the first EOB's indicated the services were denied as follows: "\$1,118. is what a hospital receives for a 1-day, in-patient, surgical stay, this is thought to be reasonable payment for an ambulatory surgical center."

### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due
2/6/04	Ambulatory Surgical Center Care	1	\$2,045.00

### 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 (213.3% to 290% of Medicare for year 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 and considering the similarity of the various procedures involved in this surgery, staff selected a reimbursement amount in the lower end, of the Ingenix range. In addition, the reimbursement for the secondary procedures were reduced by 50% consistent with standard reimbursement approaches. According to CMS ASC guidelines, lab fees and diagnostic services are included in the facility fees and not separately payable. The implantables are reimbursed at invoice plus 10%, although no invoice was provided, therefore additional reimbursement can not be recommended. 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 \$3,163.00. 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 \$2,045.00.

**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 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 \$2,045.00. 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 30-days of receipt of this Order.

Ordered by:

9 / 15 / 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.**