



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 Center 909 Ninth Ave. Fort Worth TX 76104	MDR Tracking No.: M4-05-5988-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: BOX#: 19 American Home Assurance Co.	Date of Injury:
	Employer's Name: Wal Mart Stores, Inc.
	Insurance Carrier's No.: 99256474

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

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

Position Summary: "...Requesting Party has contractual agreements with a network association for various carriers and employers other than Carrier...reimbursed at 57% of Requesting Party's usual and customary charges (for Bilateral SI Joint Injections, etc)...Requesting Party believes that the appropriate fair and reasonable' reimbursement rate that Carrier should pay...is this negotiated rate..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principal documents: 1. Respondent's response
 2. Copy of Requestors statement and EOB's

Position Summary: "...On behalf of the...insurance carrier, in response to the Requestor's dispute, regarding fee reimbursement...As a result, no further reimbursement was recommended towards the amount in dispute. Please refer to the attached re-evaluation and explanations of benefits reports." (Amounts paid: \$3,568.54 for DOS 7/19/04 and \$4,578.43 for DOS 8/16/04, total of \$8,146.97.)

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due
7/19/04	Ambulatory Surgical Center Care	1	\$0.00
8/16/04	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 the requestor nor the respondent provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). The failure to provide persuasive information that supports their proposed amounts makes rendering a decision difficult. After reviewing the services, the charges, and both parties' positions, it is determined that no other payment is due.

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, the original reimbursement on these services is within the middle area of the Ingenix range. The procedure code 64447 on DOS 7/19/04, not a common procedure code, was considered in the same cost range as the other injection procedure codes. The decision for no additional reimbursement for either DOS 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

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 & Decision by:

Authorized Signature

Typed Name

9 / 14 / 05

Date of Decision

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.