



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

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

Requestor's Name and Address: First Street Surgical 730 N. Post Oak Rd #203 Houston, TX 77024	MDR Tracking No.: M4-05-6147-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury: Employer's Name: A Rocket Moving & Delivery Inc. Insurance Carrier's No.: 99A0000273596

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

This claim has been improperly processed. Per Rule 134.1, reimbursement for services not identified in an established fee guideline shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements. We consider the amount requested to be fair and reasonable. We do not consider reimbursement that is less than that to be fair and reasonable.

Principle Documentation:

1. UB-92
2. Statement of Disputed Issues
3. Operative Report
4. Itemized Charges

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"It is the carrier's position that a) the requestor 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 reimbursement, and, d) the Commission has concluded that charges cannot be validated as true indicators of the facility's costs."

Principle Documentation:

1. Position Statement

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08/24/04	Ambulatory Surgery	1	\$730.00

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

1) This dispute relates to services provided in an Ambulatory Surgical Center (ASC) 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 evident that some other amount represents a fair and reasonable reimbursement.

During the rule development process for facility guidelines, the Commission 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 ASC services. The analysis resulted in a recommended range of reimbursement for workers' compensation services provided in ASC facilities. In addition,

both ASCs and insurance carriers provided information related to commercial market payments for ASC services. This information provides a 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 within the reimbursement range recommended by the Ingenix study (from 213.3 to 290% of Medicare for the 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 staff selected a reimbursement amount in the lower end of the Ingenix range. In addition, reimbursement for the secondary procedures was 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.

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 a fair and reasonable reimbursement amount for the services is \$1,971.00. Since the insurance carrier previously paid a total of \$1,241.00 for these services, the health care provider is entitled to an additional reimbursement in the amount of \$730.00.

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 \$730.00. 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:

10/19/05

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.