Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $2,641.33 for date of service 05/22/01.

   b. The request was received on 03/18/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 12/20/01
   b. HCFA 1450
   c. EOB(s)
   d. Example EOB(s) from other carriers
   e. Initial Request for Medical Dispute dated 01/31/02
   f. Medical Records
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 03/20/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 03/22/02. The response from the insurance carrier was received in the Division on 04/08/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

3. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 12/20/01 that they bill all payers identically regardless of whether the injury resulted on the job or not. The Requestor supplied a list of percentage reimbursement of all it's cases during the years of 1998 and 1999. This chart indicates that the average of all payers is 80% and and for Texas Workers' Compensation payers it is 84%. A chart that shows the percentage of payment by Texas Workers' Compensation carriers for the year of 2000 has also been submitted. The provider supplied EOB(s) from other insurance carriers preceding 09/11/00 that were paid at 100%. The provider states, "This sampling of 100% payment for services rendered at…evidences that: Acceptance of fees for services at…as fair and reasonable occurs across the spectrum of insurances." The provider indicates that Ambulatory Surgical Centers (ASC) are not covered by the Medical Fee Guidelines so they must be paid at a fair and reasonable rate.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 05/22/01.

2. The provider billed the carrier $3,759.33 for services rendered on 05/22/01.

3. The carrier reimbursed the provider $1,118.00 for date of service 05/22/01.

4. The amount in dispute per the provider representative is $2,641.33 for 05/22/01.

5. The services provided by the provider include such items as O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy services, Radiology services, anesthesia equipment services, EKG/ ECG monitor services, and Recovery Room services.

6. The carrier denied the billed charges by denial code "M – REDUCED TO FAIR AND REASONABLE" on the 08/03/01 EOB. The 09/18/01 reconsideration EOB listed the denial code of "F – REIMBURSEMENT FOR YOUR RESUBMITTED INVOICE HAS BEEN CONSIDERED BASED ON USUAL, CUSTOMARY AND REASONABLE CHARGES FOR PROVIDERS IN YOUR GEOGRAPHIC (ZIP CODE) AREA. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME." The dispute will be reviewed by the Medical Review Division as a fair and reasonable dispute.

V. RATIONALE

Medical Review Division's rationale:

Per the Texas Worker's Compensation Act and Rules §413.011:
"(b) Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The medical reports indicate that the services were performed on a worker with the ICD-9 Code diagnosis of 356.9. The EOB(s) from other insurance carriers submitted by the Requestor show similar ICD-9 Codes. All of the EOB(s)submitted do show that the Requestor was paid at 100% of the billed charges.

However, the additional information provided by the Requestor should not be overlooked. The Requestor has provided a chart that indicates what all the other workers' compensation carriers in Texas pay on an average. In a comparison of the three charts titled "List of Percentage Payments by Texas WC Insurances" and separated by years (1998-1999, 1999, and 2000), it was noted that there has been a consistent payment policy of many of the carriers to pay approximately 85% of the billed charges. There are carriers who have paid less and some that have paid more. There has also been a decline in the number of carriers who pay at 100% or above from 1998 to 2000. In 1998-99, 28% of the carriers paid at or above 100% and in 2000 only 13% paid at this rate. Also, the rate of payment below 85% for these same years has ranged from 28% to 31%. The figure for the carriers who paid between 86% to 100% for 1998-99 is 16% and for 1999 and 2000, it is 13% each. As the provider has supplied this information in his packet to prove his fees are fair and reasonable, then it will be accepted as an accurate reflection of the payment policies of carriers in the Texas Workers' Compensation system for this particular clinic.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. The carrier's response to the request to medical dispute was untimely, therefore, no information from that response can be considered. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. In this case, the provider submitted EOB(s) from other carriers that indicates those carriers paid 100% of the billed charges. The Requestor also provided additional information to indicate that the average of all workers' compensation insurance carriers in the state of Texas pay an average of 84% of the billed charges. This substantiates that the majority of the carriers agree that an average of 84% of the billed charges are a fair and reasonable reimbursement. The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. However, in this case, the provider submitted enough information to support the argument that the fees charged should be paid at 84% of the billed cost. Therefore, reimbursement is recommended in the amount of $2,039.84.
($3,759.33 x .84 = $3,157.84 - $1,118.00 = $2,039.84)

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $2,039.84 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 15th day of May 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm