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 $8,200.16 for date of service, 07/17/01.

   b. The request was received on 07/15/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Position Statement taken from the Table of Disputed Services
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2 The Commission requested two copies of additional documentation via a Fee Letter (MR116) that was mailed to the Requestor on 07/31/02. The Requestor did not respond per Rule 133.307 (g)(3). Therefore, the commission could not forward any additional documentation to the Respondent per Rule 133.307 (g)(4). There is no initial or 14 day response from the Carrier. The "No Response Submitted" sheet is reflected in Exhibit II in the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Taken from Table of Disputed Services
   "Unbundling rule not applied to outpatient services.

2. Respondent: No response.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 7/17/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. The Provider billed the Carrier $9,155.16, for date of service 07/17/01.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $900.00 for services rendered on the date of service in dispute above and denied additional reimbursement as "G,*226 INCLUDED IN GLOBAL CHARGE, *M,426 REIMBURSED TO FAIR AND REASONABLE."

5. The amount left in dispute is $8,200.16 for the date of service 07/17/01.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…."

Section 413.011 (b) of the Texas Labor Code states, "Guidelines for medical services 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 fees 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 Review Division has reviewed the file to determine which party has provided the most persuasive evidence in regards to fair and reasonable. The provider has not submitted additional reimbursement data for the charges billed for similar services. The requestor, per rule 133.307(g)(3)(d), must provide documentation "…if the dispute involves health care for which the commission has not established a maximum allowable reimbursement that discusses, demonstrates and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines);". The carrier, according to their denial on the EOB, asserts that they have paid a fair and reasonable reimbursement, but have not submitted a methodology to support their reimbursement. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and
explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". 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, the provider has the responsibility to support their charges are fair and reasonable as the requestor. In this case, the Requestor has not provided documentation to support their position that the amount billed is fair and reasonable as required by Rule 133.307(g)(3)(d). Therefore, additional reimbursement **is not** recommended.

The above Findings and Decision are hereby issued this 21st day of March 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd