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 $3,639.00 for date of service, 08/16/01.

   b. The request was received on 08/12/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Example EOBs from other Carriers
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. UB-92(s)
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Medical Records
   e. Methodology
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/20/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/23/02. The response from the insurance carrier was received in the Division on 09/25/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 09/11/02

   "We are appealing the amount disallowed on the above mention [sic] claim. These charges are for **FACILITY FEES,** not professional fees. We feel that 28% paid on a right knee arthroscopy with chondroplasty is not fair or reasonable. We feel that (Carrier) should reimburse us more appropriately as $1438.46 does not cover our costs to perform this surgery….(Carrier) has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85%-100% of our billed charges, and group carriers are allowing 100% of our billed charges. Enclosed are examples of bills for the same type of treatment of other patients and their insurance companies interpretation of fair and reasonable as shown by the amounts paid…."

2. Respondent: Letter dated 09/25/02

   "…The dispute in this case is in regard to the Requestor's entitlement to additional reimbursement for facility charges associated with CPT Code 27425 – Lateral retinaculer release (any method), CPT Code 29876 – Synovectomy, major, two or more compartments (eg, medial or lateral) and CPT Code 29879 – Abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling. The total billed by the requestor as a facility fee is $5077.46. The Respondent, (Carrier) paid $1438.46. The amount in dispute is $3639.00. The Requestor has failed to establish that its charges and the reimbursement it seeks are fair and reasonable and comply with the Texas Workers' Compensation Act or TWCC Rules."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/16/01.

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. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $5,077.46 for services rendered on the above date in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $1,438.46 for services rendered on the above date in dispute.

5. The Carrier's EOBs denied any additional reimbursement as "705 -M – No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area.; 907 – N-Not appropriately documented/Texas required bill identification."

6. Per the Requestor's Table of Disputed Services, the amount in dispute is $3,639.00 for services rendered on the above date in dispute.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…." The carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their payment methodology. The Provider has submitted example EOBs from other Carriers.

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;

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

2. reference its method in the claim file; and

3. 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;".

(Carrier's Third Party Administrator [TPA]) methodology incorporates information from 6 states, which have adopted a system to determine ASC charges based on intensity levels. The range is from 1 (low) to 8 (high), which is determined based on where the CPT Code falls in the HCFA intensity grouper list. (TPA) averaged the payments in each level for the 6 states and designated this as the base fee for each intensity level. (TPA) also takes into account local economic factors and applies HCFA' s wage index factor to the base fees. If the specific area is not addressed in the wage index, (TPA) uses the state average.

(TPA) sums up its methodology, indicating it generates fair and reasonable fees utilizing a well accepted intensity grouper and average prevailing usual and customary reimbursement from a geographically diverse set of workers' compensation fee schedules. There is no discounting from mean payments; a local economic adjustor is applied to the reimbursement; and additional payments are made for extraordinary supplies and lab testing.

The Respondent included attachments to further reflect its methodology. Attachment A indicates grouper numbers, CPT codes, and range of charges. Attachment B compares Medicare rates for ASC bills with states that have a similar payment schedule. Attachment C is the wage index used to take into account geographical differences. Attachment D shows samples of Texas ASCs reimbursement.

(TPA) provides a list of Texas ASC centers (bills processed in May and June 2000) that have been paid based on (TPA) methodology. The (TPA) indicates that it has canvassed other payers in the system who reimburse on the average of 110% to 140% of Medicare allowable rates and even though (TPA) does not use Medicare, it compares favorably because it pays an average of 150% of Medicare.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence. Pursuant to TWCC Rule 133.307 (g) (3) (D), the requestor has submitted EOBs from other Carriers; however failed to submit documentation that "…discusses, demonstrates, and justifies that the payment being sought is a fair and reasonable rate of reimbursement…." Respondent has provided their methodology, which conforms to the additional criteria of Sec. 413.011 (d).

The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. In this case, the Requestor has failed to support their position that the amount billed is fair and reasonable and the Respondent has submitted enough information to support the argument that the amount reimbursed represents a fair and reasonable reimbursement. Therefore, **no additional** reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D); and (j) (1) (F).

The above Findings and Decision are hereby issued this 14th day of April 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt