Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

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: Vista Healthcare 4301 Vista Road Pasadena, Texas 77503	MDR Tracking No.: M5-04-0215-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: One Beacon Insurance Company Box 29	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The insurance carrier granted preauthorization for the lumbar epidural injection and improperly reduced the payment for these services. Preauthorized treatment is not allowed to be retrospectively reviewed for medical necessity. The provider asserts that they are entitled to $5,028.25 (the amount charged of $5,983.25 minus the amount paid by the carrier of $900.00). Provider included copies of the billing forms, the preauthorization approval for the primary procedure (coded as ASC), and the request for reconsideration.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The insurance carrier reduced the bill on two grounds, "F" reduced per fee guidelines and "V" denied portions of the bill as unnecessary services based on a peer review report. Response included a copy of the Explanation of Benefits and a copy of the peer review report.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
10/12/01	Lumbar Epidural Steroid Injection with Fluoroscopy	All	$0.00

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

This dispute relates to services provided in an Ambulatory Surgical Center (ASC) or other freestanding outpatient setting which are not covered by a fee guideline for the date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Rule 134.1. This dispute was initially designated as a medical necessity dispute based upon the Explanation of Benefits presented by the insurance carrier. However, the medical necessity of the health care service was resolved when the carrier approved the preauthorization request from the requestor. Accordingly, the dispute was retracted from the Independent Review Organization and will be processed as a fee dispute.

The preauthorization rule includes language that the carrier is liable for the reasonable costs associated with preauthorized healthcare. In this situation, the insurance carrier preauthorized the epidural steroid injection with fluoroscopy in an ASC setting. However, the insurance carrier denied payment, in part, with a peer review report opined that the treatment was not medically necessary. Preauthorization is designed to secure a prospective opinion regarding the medical necessity of the surgical intervention, which in this case, was approved by the insurance carrier. There is no requirement in the rules that

require a health care provider to preauthorize every component of an ASC or outpatient service. Therefore, it is not appropriate to submit this dispute to an Independent Review Organization (IRO) for a decision on medical necessity, the carrier found that the treatment was medically necessary when they approved preauthorization. Sending this dispute to an IRO would simply increase the cost to the parties without any benefit to the process.

However, approving a preauthorization request is not an absolute guarantee of payment for the amount charged. The insurance carrier is permitted to audit a bill for unbundling and other fee-related issues. In addition, the carrier is charged with determining a "fair and reasonable" reimbursement. The carrier did reduce the bill for each line item using the reason code "F", denoting that it was reduced per the fee guideline. Since there is no fee guideline, it appears the carrier reduced the payment by establishing what they found to be the "fair and reasonable" reimbursement. While the carrier did not include other reduction reasons based on the information contained in this particular file, the use of this particular code does mandate any particular outcome through medical dispute resolution. While more recent rules on medical dispute resolution include certain regulatory dictates on waivers for failure to timely identify appropriate reduction reasons, these provisions do not apply to this particular dispute. Since this dispute was filed before January 1, 2003, the previous medical dispute resolution rule applies (which does not contain the same "waiver" language). Accordingly, this dispute must be decided based on the requirements of Act and rules related to "fair and reasonable" reimbursement. While the requestor purports the amount charged is the "fair and reasonable" reimbursement, it is noted that the Division has repeatedly found in the adoption of various fee guidelines that the usual and customary charge is not a good indicator of the "fair and reasonable" reimbursement due under the provisions of the Texas Labor Code.

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. Neither party provided information to show that their purported amount is similar to what is paid in other similar settings, promotes access to health care, or ensures medical cost containment. The failure to provide this type of information makes rendering a decision difficult. However, a comparison to what is paid in the Medicare system in both outpatient and ASC settings appears to show that the carrier paid more than the reimbursement in that particular system. Given the lack of information to the contrary, I find that the fair and reasonable reimbursement is the amount previously paid by the insurance carrier and no additional reimbursement is due.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.1
28 Texas Administrative Code Sec. 134.305 (as existed for processing of this dispute)
28 Texas Administrative Code Sec. 134.600

PART VII: DIVISION DECISION

Based upon the review of the disputed healthcare services, the Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Allen C. McDonald, Jr.	January 2, 2006
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.