TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION
FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Freedom Ambulance

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-1884-01

Carrier's Austin Representative Box
Number 54

Fee Dispute Request Received
February 24, 2014

Response Submitted by:
Texas Mutual Insurance Co

REQUESTOR POSITION SUMMARY

"We have sent this claim to Texas Mutual twice and they denied both times for received past filing deadline. The attached documentation shows that we sent the claim to them as soon as we were advised that it was a workers' compensation claim. Blue Cross Blue Shield paid the claim before we were aware of this."

RESPONDENT POSITION SUMMARY

"The following is the carrier's statement with respect to this dispute…Texas Mutual on 11/11/13 received a bill from FREEDOM AMBULANCE LLC."

SUMMARY OF REQUEST AND DIVISION ORDER

Disputed Dates of Service	Disputed Service	Disputed Amount	Division Order
February 27, 2013	Ambulance Transport - Ground	$2,385.00	$0.00

AUTHORITY

Texas Labor Code §413.031 (c) In resolving disputes over the amount of payment due for medically necessary services for treatment of the compensable injury, the role of the medical fee dispute resolution program is to adjudicate the payment given the relevant statutory provisions and commissioner rules.

Rule at 28 Texas Administrative Code §133.307 sets out the process for medical fee dispute resolution applicable to requestors, respondents, and the Division.

Claim Adjustment Reason Codes
The insurance carrier reduced payment for the disputed service with the following claim adjustment reason codes:

1. Explanation Of Benefits (EOB) issued by Texas Mutual on November 20, 2013
   - 29 The time limit for filing has expired
2. Explanation of Benefits issued (EOB) issed by Texas Mutual on January 10, 2014
   - 29 The time limit for filing has expired
   - W3 This bill has been identified as a request for reconsideration

Findings

Freedom Ambulance, a ground ambulance transport provider, requested payment from Texas Mutual, a workers' compensation carrier, for service provided to a covered injured employee. Texas Mutual issued an initial EOB in which it denied payment for "29-time limit for filing has expired."

In its request for reconsideration, Freedom Ambulance argued that it qualified for an exception to the 95-day filing deadline and asked Texas Mutual to reconsider payment. Texas Mutual responded and maintained its original denial.

Freedom Ambulance was dissatisfied with the outcome of reconsideration and proceeded to file a medical fee dispute to the Division.

Freedom Ambulance has the burden to prove that the disputed amount is due. The Division's role is to decide whether that burden is met. In this case, Freedom Ambulance has the burden to: (1) prove that it qualified for an exception to the 95-day filing deadline; and (2) demonstrate that the disputed amount is consistent with the applicable Division reimbursement rule(s).

1. *Did Freedom Ambulance timely submit its medical bill to Texas Mutual for payment?*

   Health care providers must file a complete medical bill within 95 days from the date of service;[1] however there are exceptions to this 95-day deadline. If an exception is met, the health care provider's deadline to submit a complete medical bill to the correct workers' compensation carrier is tolled up to and including the date that the health care provider is notified that a group accident, group health, HMO (health maintenance organization), or the incorrect workers' compensation carrier was erroneously billed.[2] The health care provider then has 95 days from the date that it is notified to bill the correct workers' compensation carrier.

   Documentation supports that Freedom Ambulance erroneously billed Blue Cross Blue Shield (BC/BS) for the services in dispute. For that reason, Freedom qualified for the statutory exception to the 95-day deadline.

   The following documentation supports that Freedom filed its medical bill well within 95 days after it was notified of the erroneous filing:

   - October 8, 2013 is the date that Freedom Ambulance was notified by letter from BCBS that the transport was for a work-related injury. This is the date that Freedom was notified of the erroneous filing.
   - Texas Mutual states that it received the medical bill from Freedom on November 11, 2013. That bill was audited on November 20, 2013. Both dates are well within 95 days from October 8, 2013 – the date Freedom was notified of the erroneous filing.

   In the absence of any refuting information from Texas Mutual, the Division finds that Freedom Ambulance met its burden to prove that it qualified for an exception under Texas Labor code §408.0272 and that it filed the service in dispute within 95-days from the date that it was notified of the initial erroneous billing to the health plan.

2. *What standard for payment applies to the services in dispute?*

   The service in dispute is a ground ambulance transport service billed under Healthcare Common Procedure Coding System (HCPCS) service code A0429 and corresponding mileage code A0425. Under the Division's general reimbursement Rule at 28 Texas Administrative Code §134.1(e), payment for health care is calculated by applying a fee from an adopted Division rule or by applying a negotiated contract rate. In the absence of an applicable fee calculation or a negotiated contract, the payment is subject to the Division's general fair and reasonable requirements described in §134.1(f).[3]

   Review of the Division's fee guidelines finds that there is no fee guideline with an adopted reimbursement methodology for **ground ambulance services**. Furthermore, review of the documentation finds no evidence

[1] Texas Labor Code § 408.027 and 28 Texas Administrative Code §133.20
[2] Texas Labor Code § 408.0272
[3] 28 Texas Administrative Code §134.1

of a negotiated contract. Consequently, the Division's general fair and reasonable standard of payment applies to the service in dispute.

3. *Did Freedom Ambulance meet its burden to prove that the amount it seeks is a fair and reasonable payment?*

   28 Texas Administrative Code §133.307(c)(2)(O) states that when filing a fee dispute for services paid under the Division's general fair and reasonable standard, the health care provider shall provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title . . . when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."[4]

   On September 17, 2018 the Division's medical fee dispute program sent a request to Freedom Ambulance for information. The request was sent via email delivery to the contact listed on the medical fee dispute form filed by Freedom Ambulance. The Division asked Freedom Ambulance to provide documentation that discusses, demonstrates or justifies that the payment amount sought is fair and reasonable. The listed due date was October 1, 2018.

   Freedom Ambulance did not respond to our request. For that reason, we base our decision on the information available and conclude that Freedom Ambulance did not meet its burden to prove that the disputed amount is fair and reasonable rate of payment.

Decision

Freedom Ambulance did not meet its burden to prove that the amount of payment it seeks from Texas Mutual is fair and reasonable. Consequently, Freedom Ambulance's request for reimbursement is denied.

DIVISION ORDER

The undersigned has been delegated authority by the Commissioner of the Division of Workers' Compensation to sign this official order. For the reasons stated, the amount ordered is $0.00.

Authorized Signature

	Martha P. Luévano	October 26, 2018
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this Division decision. To appeal, submit form DWC Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at https://www.tdi.texas.gov/forms/form20numeric.html.

Follow the instructions on pages 3 and 4. The request must be received by the division within twenty days of your receipt of this decision. This decision becomes final if the request for review of a this decision is not timely made.

The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

If you have questions about the DWC Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, Option 1.

[4] 28 Texas Administrative Code §133.307