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
South Texas Emergency Care

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-16-3572-01

Carrier's Austin Representative Box
Box 54

Fee Dispute Request Received
July 29, 2016

Response Submitted by:
Texas Mutual Insurance Co

REQUESTOR POSITION SUMMARY

"Patient suffered a workers compensation related claim on [redacted] for a back injury and on 1-12-2016 he was suffering from back pain rating it an 8 from 1-10 pain scale."

RESPONDENT POSITION SUMMARY

"The documentation from the requestor and the facility does not indicate a medical emergency as defined by Rule 133.2. No payment is due."

SUMMARY OF REQUEST AND DIVISION ORDER

Disputed Dates of Service	Disputed Service	Disputed Amount	Division Order
January 12, 2016	Ambulance Transport - Ground	$782.00	$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.

Denial Reason

Explanation of Benefits (EOB) issued March 23, 2016 and June 9, 2016 indicate that the insurance carrier denied payment for the disputed service based upon codes 226-The submitted documentation does not support the services being billed.

Findings

South Texas Emergency Care, a ground ambulance transport provider, requested payment from Texas Mutual Insurance Co, a workers' compensation carrier, for service provided to a covered injured employee. The carrier denied payment and explained that the ground ambulance provider did not provide documentation to "support the services being billed." Provider requested reconsideration and the carrier maintained its original denial reason. The provider was dissatisfied with the outcome of reconsideration and proceeded to medical fee dispute.

South Texas Emergency Care 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, South Texas Emergency Care has the burden to: (1) prove that the service in dispute was properly documented; and (2) demonstrate that the disputed amount is a fair and reasonable rate of payment for the service in dispute.

1. *Did the provider support that the services were properly documented?*

   Review of the documentation provided by both parties finds only two explanation of benefits both of which indicate a denial of payment based upon insufficient documentation. In its response, Texas Mutual further asserted that the documentation did not "indicate an emergency."

   The documentation provided meets the definition of an emergency found at 28 Texas Administrative Code §133.2(5)(A) principally because the injured employee reported that he was in severe pain. Specifically, the documentation indicates that "Patient currently rated his pain to ems at an 8 out of 10."

   The division concludes that South Texas Emergency Care properly documented the service and that the definition of emergency pursuant to Rule §133.2(5)(A) was met. Texas Mutual Insurance Co's denial reason is not supported.

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

   The services in dispute are all part of a ground ambulance transport billed under Healthcare Common Procedure Coding System (HCPCS) service codes A0429, A0425, A0398 and A0422. 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).[1]

   Review of the Division's fee guidelines finds that there is no fee guideline with an adopted reimbursement methodology for ground ambulance services.[2] Furthermore, review of the documentation finds no evidence of a negotiated contract. Consequently, the Division's general fair and reasonable standard of payment applies to the service in dispute.

3. *Did South Texas Emergency Care meet its burden to prove that the amount it seeks is a fair and reasonable payment for the service in dispute?*

   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."[3]

   On August 1, 2018, the Division invited South Texas Emergency Care to provide documentation that discusses, demonstrates or justifies that the payment amount sought is fair and reasonable.

No information was provided at that time, nor has it been provided to date.

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[1] 28 Texas Administrative Code §134.1

[2] See Medical Fee Dispute Decision M4-12-1490-01

[3] 28 Texas Administrative Code §133.307

We conclude that South Texas Emergency Care did not provide documentation that discusses, demonstrates and justifies that $782.00 is a fair and reasonable rate of payment. South Texas Emergency Care therefore did not meet its burden to prove that the amount requested meets the Division's fair and reasonable standard of payment. Consequently, South Texas Emergency Care 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

		April 3, 2019
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this 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.