TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION
FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Area Metropolitan Ambulance

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-17-0534-01

Carrier's Austin Representative Box
Box 44

Fee Dispute Request Received
October 26, 2016

Response Submitted by:
No response

REQUESTOR POSITION SUMMARY

"We only received payment…which is well below the minimum payment acceptable."

RESPONDENT POSITION SUMMARY

No response

SUMMARY OF REQUEST AND DIVISION ORDER

Disputed Date of Service	Disputed Service	Carrier Payment for A0427	Additional Amount Sought	Division Order
June 19, 2016	A0427	$85.46	$386.13	$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 July 18, 2016
   - 790 This charge was reimbursed in accordance with the Texas medical fee guidelines.

Findings

Area Metropolitan Ambulance, a ground ambulance transport provider, billed Old Republic Insurance Co, a workers' compensation carrier, for ambulance services provided to a covered injured employee. The carrier paid

$85.46 for the disputed A0427 ground ambulance transport. Area Metropolitan Ambulance contends that the payment made is "well below the minimum payment acceptable" and is seeking an additional $386.13.

Area Metropolitan Ambulance has the burden to prove that the additional amount is due.

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

   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.

2. *Did Area Metropolitan Ambulance meet its burden to prove that the additional amount it seeks results in 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 Area Metropolitan Ambulance 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. We therefore base our decision on the information available and conclude that Area Metropolitan Ambulance did not meet its burden to prove that the disputed amount is fair and reasonable rate of payment.

Decision

Area Metropolitan Ambulance did not meet its burden to prove that the additional reimbursement it seeks results in a fair and reasonable payment for the service in dispute. Consequently, Area Metropolitan Ambulance's request for additional 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

Signature	Medical Fee Dispute Resolution Director	April 3, 2019 Date

[1] 28 Texas Administrative Code §134.1

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

[3] 28 Texas Administrative Code §133.307

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.