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
Republic EMS

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-3183-01

Carrier's Austin Representative Box
Box 54

Fee Dispute Request Received
February 15, 2019

Response Submitted by:
Texas Mutual Insurance Co

REQUESTOR POSITION SUMMARY

"It is erroneous to deem the reimbursement rate of $462.24 'fair and reasonable.'…There is no question that the referenced transport was emergent and medically necessary."

RESPONDENT POSITION SUMMARY

"The question is not medical necessity…but the appropriate reimbursement for the ambulance services…The requestor demands full billed changes but offers no justification."

SUMMARY OF REQUEST AND DIVISION ORDER

Disputed Dates of Service	Disputed Service	TMIC Paid	Additional Amount Sought	Division Order
November 10, 2018	Ambulance Transport - Ground	$862.24	$2,069.27	$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 December 10, 2018
   - 426 Reimbursed to fair and reasonable
2. Explanation of Benefits issued January 24, 2019
   - CAC-193 Original payment decision is being maintained
   - 724 No additional payment after a reconsideration of services
   - 426 Reimbursed to fair and reasonable

Findings

Republic EMS, 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 paid $862.24. Republic EMS was dissatisfied with the payment and requested an additional payment of $2,069.27 through reconsideration. The carrier maintained that $862.24 was a fair and reasonable payment amount. Republic EMS was dissatisfied with the outcome of its request for reconsideration and filed this medical fee dispute.

Republic EMS has the burden to prove that an additional $2,069.27 is due. The Division's role is to decide whether Republic EMS has demonstrated that a total payment of $2,931.51 results in a fair and reasonable payment for the service in dispute.

1. *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 A0427 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).[1]

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

2. *Did Republic EMS 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."[2]

   On April 8, 2019, the Division sent a request to Republic EMS for documentation that discusses, demonstrates or justifies that the payment amount sought is fair and reasonable. The request was delivered via email to the contact listed on the medical fee dispute form.

   The requested information was not provided at that time, nor has it been provided to date. For that reason, we base our decision on the information available and conclude that Republic EMS did not meet its burden to prove that a total payment of $2,931.51 results in a fair and reasonable payment for the service in dispute.

Decision

Republic EMS did not meet its burden to prove that a total payment of $2,931.51 results in a fair and reasonable payment for the service in dispute. Consequently, Republic EMS request for additional reimbursement is denied.

[1] 28 Texas Administrative Code §134.1
[2] 28 Texas Administrative Code §133.307

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 23, 2019
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.