TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION
FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
APOLLO MEDFLIGHT

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-0512-01

Carrier's Austin Representative Box
Box 54

Fee Dispute Request Received
October 23, 2019

Response Submitted by:
TEXAS MUTUAL WORKERS COMPENSATION INSURANCE

REQUESTOR POSITION SUMMARY

"Apollo MedFlight charges are being paid subject to a Workers Compensation (fee schedule-that doesn't exist) amount or by usual and reasonable fee based on faulty data and should have been paid in full … We have submitted documentation demonstrating that our market-driven charges reflect the cost of doing business to anyone whom requires our services."

RESPONDENT POSITION SUMMARY

"The requestor demands its full billed charges. The requestor offer no justification for its demand other than an erroneous federal preemption argument … Texas Mutual developed and consistently applied a methodology for issuing fair and reasonable reimbursement to air ambulance providers. An air ambulance company's full billed charges are not fair and reasonable."

SUMMARY OF REQUEST AND DIVISION ORDER

Disputed Date of Service	Disputed Service	Carrier Payment for A0427 and A0425	Additional Amount Sought	Division Order
November 6, 2018	A0427 and A0425	$612.93	$1,208.77	$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 18, 2018
   - A14 – AMB Reimb. Is based on the 28 TAC 134.203 and Travis City. Court D-1-GN-15-004940 Final Judgment holding no pymts > 125% of Medicare are due.
   - CAC-P5 – Based on payer reasonable and customary fees. No maximum allowable. Defined by Legislated Fee arrangement.
   - 426 – Reimbursed to fair and reasonable.

Findings

Apollo MedFlight, a ground ambulance transport provider, billed Texas Mutual Insurance, a workers' compensation carrier, for ambulance services provided to a covered injured employee. The carrier paid $612.93 for the disputed A0427 and A0425 ground ambulance transport. Apollo MedFlight contends that the payment made is "based on faulty data and should have been paid in full" and is seeking an additional $1,208.77.

Apollo MedFlight 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 Apollo MedFlight 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]

   Although Apollo MedFlight asserts that "We have submitted documentation demonstrating that our market driven charges reflect the cost of doing business to anyone whom requires our services;" review of the documentation submitted by Apollo finds no such evidence. For that reason, the division finds that Apollo MedFlight failed to support its assertion that their charges reflect the cost of doing business.

   We therefore base our decision on the information available and conclude that Apollo MedFlight did not meet its burden to prove that the disputed amount is fair and reasonable rate of payment.

Decision

Apollo MedFlight 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, Apollo MedFlight's request for additional reimbursement is denied.

[1] 28 Texas Administrative Code §134.1

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

[3] 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

		November 21, 2019
Signature	Medical Fee Dispute Resolution Officer	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.