



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

ELITE MEDICAL TRANSPORT

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-22-0189-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

September 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 3, 2021	A0428-HN and A0425-HN	\$708.00	\$0.00
Total		\$708.00	\$0.00

Requestor's Position

"We have 95 days from the day of services to file the claim with Texas Mutual Workers' Compensation. We submitted the claim on April 23, 2021. The claim was process by the Texas Mutual Worker's Compensation on May 03, 2021 per denial letter. Claim was denied due to box 10 information was not related to work injury..."

Amount in Dispute: \$708.00

Requestor's Supplemental Position

"The amount charge for the ambulance service is fair and reasonable rate of reimbursement. Enclosed you will find proof that we received 100% payment from the department of labor."

Respondent's Position

"Texas Mutual on 6/21/2021 received a complete bill from Elite Medical Transport... The CMS1500 was returned to the provider per box 10 not work-related injury/health plan... The rationale given by the requestor for the late bill is not consistent with the Rule above 133.20(b)."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out the billing procedures for Medical Bill Submission by Health Care Provider.
3. 28 TAC §134.1 sets out general provisions regarding medical reimbursement.
4. 28 TAC §102.4 sets out the rules for non-Commission communications.
5. TLC §408.027 sets out the rules for timely submission of claims by health care providers.
6. TLC §408.0272 provides for certain exceptions to untimely submission of a medical bill.
7. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and fee guidelines.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- A14 - AMB REIMB, IS BASED ON THE 28 TAC 134.203 AND TRAVIS CTY. COURT D-1-GN-16-004940 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.
- CAC-29 - THE TIME LIMIT FOR FILING HAS EXPIRED.
- 731 - PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.
- 926 -HCP MUST SUBMIT DOCUMENTATION TO SUPPORT EXCEPTION TO TIMLEY FILING OF BILL (408.0272). NOTIFICATION OF ERRONEOUS SUBMISSION NOT INCLUDED.

Issues

1. Is the Insurance Carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for HCPCS codes A0428-HN and A0425-HN, rendered on February 3, 2021.

The insurance carrier denied the disputed services with denial reduction code(s); A14, CAC-29, 731 and 926 (description provided above.)

28 TAC §133.20(b) requires that, except as provided in TLC §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." The requestor submitted insufficient documentation to support that any of the exceptions described in TLC §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not-later than 95 days after the date the disputed services were provided.

TLC §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 TAC §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The date of service is February 3, 2021. The Division of Workers' Compensation Commissioner issued Bulletin # B-0010-20 which states in pertinent part that failure to submit a timely medical bill will be deemed an exception due to a catastrophic event under Labor Code Section 408.0272(b)(2). The DWC finds that the date of service was submitted timely and therefore, the insurance carrier's denial is not supported based on DWC Commissioner's Bulletin # B-0010-20. This date of service will be reviewed per applicable fee guideline.

2. This dispute involves payment for ambulance ground transportation services billed under HCPCS Code A0428-HN and A0425-HN. The ambulance ground transportation services do not contain a fee schedule under the Medicare Physician Fee Schedule. Consequently, a payment amount cannot be determined using the formula in the Medicare fee schedule, under 28 TAC §134.203.

Review of the submitted information finds insufficient documentation to support a negotiated contract or that the services were provided through a workers' compensation health care network.

Payment is therefore subject to the general medical reimbursement provisions of 28 TAC §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

28 TAC §134.1(f) requires that: Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011(d) requires that: Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

28 TAC §133.307(c)(2)(O) requires the requestor to 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 (relating to Medical Reimbursement) . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.

In the following analysis, the submitted information is examined to determine which party presents the best evidence to support a payment that achieves a fair and reasonable reimbursement for the services in dispute.

The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence. DWC first considers whether the requestor has met the burden to support that the payment amount requested is a fair and reasonable rate of reimbursement for the services in dispute. If the requestor's evidence is persuasive, DWC will then review the evidence presented by the respondent.

- The requestor submitted a copy of an EOB to support that a payment in the amount of \$1,640 for HCPCS codes A0434-IH and A0425-IH is fair & reasonable.
- The requestor did not explain or provide sufficient documentation to support how a payment of \$708.00 ensures quality medical care to injured workers.
- The requestor did not explain or provide sufficient documentation to support a payment of \$708.00 achieves effective medical cost control.
- The requestor did not explain or provide sufficient documentation to support a payment of \$708.00 ensures that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not explain or provide sufficient documentation to support that the proposed methodology is consistent with the criteria of Labor Code §413.011.
- The requestor did not explain or provide sufficient documentation to support that the proposed methodology satisfies the requirements of Rule §134.1.

The request for reimbursement is not supported. The requestor failed to discuss, demonstrate, and justify by a preponderance of the evidence that the payment sought is a fair and reasonable rate of reimbursement for the services in dispute. Consequently, payment cannot be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement of \$708.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

_____	_____	December 3, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.