TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ACADIAN AMBULANCE SERVICES

Respondent Name
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-1611-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
March 31, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 15, 2021	A0427 and A0425	$579.34	$0.00
	Total	$579.34	$0.00

Requestor's Position

"Acadian Ambulance (MSI) transported the patient from BSNF SNF flop am on DOS referenced above as a result of a call from for an emergency transport to 26790 St Hwy 405 Plaquemine LA-BSNK SNK Flop AM. Patient was transported directly to Ochsner Medical Complex for necessary care needed as a result of what has since been reported to AASI as a work-related injury."

Amount in Dispute: $579.34

Requestor's Supplemental Position

"I have researched further for a payment on this bill. I have received a payment of $401.53 which is paying mileage A0425 at $9.35 per mile. Per Texas fee schedule the mileage payment should be $9.5375 per mile."

Respondent's Position

"ESIS Med Bill Impact's Bill Review Department reviewed the above-mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $1117.94. Original submission paid $716.41 on 8/13/21, with an additional balance of $401.53 paid on 4/19/22."

Response Submitted by: ESIS

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.1 sets out the medical reimbursement policies.

Denial Reasons

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

- 10 – Reimbursement based on usual and customary & reasonable for this geographic region.
- 12 – Reimbursement based on Medicare's Ambulance fee schedule.
- P12– Workers' compensation jurisdictional fee schedule adjustment.
- P5 – Based on payer reasonable and customary fees. No maximum allowable define by legislated fee arrangement.
- 17 – Revised recommendation is based upon additional supporting documentation received.

Issues

1. Did the Insurance Carrier issue payment for the services in dispute?
2. Did the requestor submit documentation to support fair & reasonable reimbursement?
3. Is the Requestor entitled to additional reimbursement?

Findings

1. 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. Review of the EOB submitted supports that the insurance carrier issued a payment in the amount of $692.08 for HCPCS Code A0427 and $65.45 and $252.45 for HCPCS Code A0425. The requestor seeks additional reimbursement for the HCPCS codes A0427 and A0425.
2. 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 TAC §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).

   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.

28 TAC §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."

The requestor in support of the fair and reasonable reimbursement rate states, "I have researched further for a payment on this bill. I have received a payment of $401.53 which is paying mileage A0425 at $9.35 per mile. Per Texas fee schedule the mileage payment should be $9.5375 per mile." The DWC finds that the documentation submitted does not meet the fair and reasonable standards outlined in 28 TAC §133.307 (c)(2)(O). As a result, Acadian did not meet its burden to prove that the disputed amount is fair and reasonable rate of payment.

3. The DWC finds that Acadian did not meet its burden to prove that the amount of payment it seeks from Indemnity Insurance Company is fair and reasonable. Consequently, Acadian's request for additional reimbursement is not supported.

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.

The DWC finds the requester has established that additional reimbursement is not due.

Order

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

Authorized Signature

		June 23, 2022
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 electronico CompConnection@tdi.texas.gov.