

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Acadian Ambulance Svc of Texas

**Respondent Name**

Texas Mutual Insurance Co

**MFDR Tracking Number**

M4-23-2536-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

June 1, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 28, 2022	A0427	\$550.70	\$0.00
June 28, 2022	A0425	\$346.32	\$0.00
<b>Total</b>		<b>\$897.02</b>	<b>\$0.00</b>

### Requestor's Position

"Acadian Ambulance (AASI) transported the patient from Ward County Memorial Hospital on DOS referenced above as a result of a call from for an emergency transport to Medical Center Hospital. Patient was transported directly to the emergency department for necessary care needed as a result of what has since been reported to AASI as a work related injury."

**Amount in Dispute:** \$897.02

### Respondent's Position

"The rationale given by the requestor for the late bill is not consistent with the Rule above. Additionally, the health care provider states they did not know who the insurance carrier was for this bill, however, the attached Mednar on page 1 shows the primary payor as Texas Mutual. Our position is that no payment is due."

**Response Submitted by:** Texas Mutual

## 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 §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 Texas Administrative Code §134.20](#) sets out requirements of medical bill submission.
3. [Texas Labor Code 408.0272](#) sets out the workers compensation timely billing and exceptions guidelines.

### Denial Reasons

- CAC - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- CAC – 29 – The time limit for filing has expired
- 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service
- 891 – No additional payment after reconsideration

### Issues

1. Did the requestor support exception to timely submission of medical claim?

### Findings

1. The requestor is seeking reimbursement for ambulance services rendered in June of 2022.

The following two rules apply to receipt of medical bills.

DWC Rule 28 TAC §102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will 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 through 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 must be the next previous day that is not a Sunday or legal holiday.

DWC Rule 28 TAC §133.20 (b) states in pertinent part,

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Texas Labor Code 408.0272. (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation found in sufficient information to support that the medical bill was sent to the correct workers' compensation carrier within the required time frame or that an exception to the filing deadline exists.

No payment is 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 additional reimbursement is 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**

Signature

Medical Fee Dispute Resolution Officer

June 21, 2023  
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).