Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Acadian Ambulance Service of Texas

Respondent Name
Indemnity Insurance Company

MFDR Tracking Number
M4-23-3098-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
August 3, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 3, 2022	A0429	$482.65	$0.00
October 3, 2022	A0425	$270.54	$0.00
	Total	$753.19	$0.00

Requestor's Position

"As supported by AASI Patient Care Summary and Trip Notes AASI was Dispatched as an emergency and provided the necessary level of service required to safely and successfully transport the patient to St Elizabeth Hospital - Beaumont for additional medical care. At this time Acadian Ambulance requests that our claim, be reviewed and reprocessed for additional payment equal to the total charges billed to the Workers Compensation Insurance-ESIS."

Amount in Dispute: $753.19

Respondent's Position

"Upon receipt of the MDR requested, the bill was sent for reconsideration. A payment of $841.66 for dos 10-03-22/10-03-22 was issued on 8-24-23. Attached is a copy of the EOR and the payment screens for the bill and interest payments issued."

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 §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.1 sets out the medical reimbursement policies.
4. TLC §413.011 sets out the reimbursement policies and guidelines; treatment guidelines and protocols.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- N19 – Procedure code incidental to primary procedure.
- PI – Payer initiated reduction.
- 1 – Billed charges are equal to $0.00. Allowance is not recommended.
- 97 – Payment is included in the allowance for another service/procedure.
- 29 – Time limit for filing has expired.
- 2 – This procedure on this date was previously reviewed.

Issues

1. What are the services in dispute?
2. What is the applicable rule for determining reimbursement for ground ambulance transport services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The subject of this disagreement is the reimbursement for ground ambulance services, for which the DWC has not established a medical fee guideline. The requestor billed a total of $2,364.00 for services rendered on October 3, 2022. The insurance carrier issued a payment in the amount of $570.64 and the requestor seeks an additional payment in the amount of $182.55.
2. The disputed services are therefore, governed by 28 TAC §134.1 medical reimbursement guidelines. The insurance carrier issued a payment of $265.28 for HCPCs code A0425, and $305.36 for HCPCs code A0429. §134.1(e) and (f) states;

   (e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

(1) the DWC's fee guidelines;
(2) a negotiated contract; or
(3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

(f) 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 DWC 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."

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 DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable**."**

Review of the submitted documentation finds that:

- The requestor's position statement states, "At this time Acadia Ambulance requests that our claim be reviewed and reprocessed for additional payment equal to the total charges billed…"
- The requestor did not submit documentation to support how the requested additional payment would ensure the quality of medical care and achieve effective medical cost control.
- The requestor does not discuss or explain how the requested additional payment would result in similar reimbursement that similar procedures provided in similar circumstances received.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested additional reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 TAC §134.1. The request for additional reimbursement is therefore not supported.

3. The requestor has the responsibility of supporting their request for reimbursement by a preponderance of the evidence. According to DWC, the requestor failed to provide sufficient information to comply with that requirement. The DWC finds that the requestor did not comply with DWC rules and the Labor Code, therefore, payment for HCPC codes A0429 and A0425 is not 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 12, 2024 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.