



# 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 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

DIXIE AMBULANCE SERVICE

**Respondent Name**

MIDWEST EMPLOYERS CASUALTY COMPANY

**MFDR Tracking Number**

M4-09-9441 -01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 15, 2009

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This claim was paid on a Texas fee schedule and the accident occurred in the state of Utah. Our rates are state regulated. A payment resulting in a 2/3 reduction is not reasonable."

**Amount in Dispute:** \$673.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The carrier's position remains consistent with its EOBs. See attached."

**Response Submitted by:** Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2008	Ambulance Services	\$673.00	\$673.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
- 28 Texas Administrative Code §134.203 sets out the medical fee guidelines for professional medical services.
- Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
- The services in dispute were reduced by the respondent with the following explanation codes:
  - W1 – Workers Compensation State Fee Schedule Adjustment
  - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement (Use Group Codes PR or CO depending upon liability).
  - W3 – Additional payment made on appeal/reconsideration. \$1,004.80
  - W3 – Additional payment made on appeal/reconsideration. \$490.60

## Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Are the insurance carrier's payment reduction reasons supported?
3. How is reimbursement for ambulance services established in Texas Workers' Compensation?
4. Has the requestor justified that the payment amount sought is a fair and reasonable rate of reimbursement?
5. Has the respondent justified that the payment made is a fair and reasonable rate of reimbursement?
6. Is additional reimbursement due?

## Findings

1. The requestor is a health care provider that rendered disputed services in the state of Utah to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. The services in dispute are ambulance transport services billed under procedure codes A0427 and A0425. The insurance carrier reduced payment for the disputed services with claim adjustment reason codes W1 – "Workers Compensation State Fee Schedule Adjustment "; and 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement (Use Group Codes PR or CO depending upon liability)." The Division has not established a fee schedule or fee guideline for ambulance services. No documentation was presented to support a fee schedule/maximum allowable or contracted/legislated fee arrangement applicable to the services in dispute.

The Division notes that Rule 134.203, *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 *Texas Register* 364, is not applicable to ambulance transportation services. Per 28 Texas Administrative Code §134.203(d):

The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
- (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
- (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

That is, each service payable at 125 percent under (d)(1) must be: (1) a HCPCS Level II code A, E, J, K, or L; (2) durable medical equipment, a prosthetic, orthotic or supply; and (3) included in Medicare's DMEPOS fee schedule. All three requirements must be met for a service to be payable under the rule. Subsection 134.203(d) may not be dissected in a manner that gives some portions meaning while rendering others meaningless. All services payable under this section must meet all the requirements to be eligible for payment at 125% of the Medicare (DMEPOS) rate. This section cannot be arbitrarily applied to services that do not meet these criteria, nor can it be interpreted to include Medicare fee schedules outside of DMEPOS.

The preamble to Rule 134.203 supports that the 125% payment adjustment factor was not intended to apply to transport services or the Medicare ambulance fee schedule:

Adopted §134.203 maintains reimbursement of Healthcare Common Procedure Coding System (HCPCS) Level II codes at the level specified in §134.202, 125 percent of fees listed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule, or 125 percent of the published Texas Medicaid fee schedule for durable medical equipment if the code has no published Medicare DMEPOS rate. (33 *Texas Register* 364)

The supplementary preamble to former Rule 134.202 further specifies that:

S. Durable Medical Equipment. The Commission provides this supplement to the April 2002 preamble concerning Durable Medical Equipment (DME). The Commission was required by statute to adopt Medicare weights, values and measures along with the associated Medicare reimbursement methodologies. Medicare uses the DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics and Supplies) fee schedule to determine reimbursement for Health Care Procedural Coding System (HCPCS)

Level II items. The new rule adopts the Medicare DMEPOS and supplements the DMEPOS with the Texas Medicaid Fee Schedule Information, Durable Medical Equipment/Medical Supplies Report J, for items not included in the DMEPOS. (27 *Texas Register* 4048)

Both preambles explain and clarify that the only service types contemplated in the reimbursement provision of §134.203(d) and its sub-paragraphs were durable medical equipment, prosthetics, orthotics and supplies found in Medicare's DMEPOS fee schedule.

Based on the plain reading of §134.203(d) , and clarifications found in the above mentioned preambles, neither subparagraph (d)(1) nor (d)(2) can be construed as applicable to the transportation services in dispute. That is, the maximum reimbursement amounts and methods listed in subparagraphs (d)(1) and (d)(2) are not only limited to items that are billed using HCPCS Level II codes but that are also durable medical equipment, prosthetics, orthotics or supplies. Further, subparagraphs (d)(1) and (d)(2) are intended to be read together, as the "published Medicare rate" language in subparagraph (d)(2) refers *exclusively* to items listed in Medicare's DMEPOS fee schedule.

Even if subsection (d) does not apply solely to DMEPOS services, subparagraph (d)(2) would *still* not apply to ambulance services because there *are* published Medicare rates. Thus, at most, subparagraph (d)(3) would apply and implicate fair and reasonable reimbursement pursuant to §203(f) and 28 Texas Administrative Code §134.1.

The services in dispute are A0427 – Ambulance service, advanced life support, emergency transport; and A0425 – Ground mileage, per statute mile; both classified as Transportation Services. The Division finds that the services in dispute are not durable medical equipment, prosthetics, orthotics or supplies, and are not found in the Medicare DMEPOS fee schedule. The respondent's payment reduction reason code of W1 – "Workers Compensation State Fee Schedule Adjustment" is therefore not supported.

3. For the reasons stated above the Division concludes there is no applicable medical fee guideline for ambulance services. No documentation was found 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 Texas Administrative Code §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 §134.1(f).

In the following analysis, the Division examines the positions of both parties, and any evidence presented in support of, or to refute, each party's determination of a fair and reasonable payment amount, in order to establish which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the disputed services. The requestor has the burden of proof in this dispute. The standard of proof required is by a preponderance of the evidence.

4. Reimbursement for the disputed ambulance services is subject to the provisions of 28 Texas Administrative Code §134.1, which requires that medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with: (1) the Division'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 §134.1(f).

Subsection 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."

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004). Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

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. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, 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 . . . when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

The Division first reviews the information presented by the requestor to determine whether it has met its burden to prove that the payment amount it is seeking is a fair and reasonable rate of reimbursement for the services in this dispute. If the requestor’s evidence is persuasive, then the Division will review the respondent’s evidence.

Review of the submitted documentation finds that:

- The requestor asserts in its original position statement that “the accident occurred in the state of Utah. Our rates are state regulated. A payment resulting in a 2/3 reduction is not reasonable.”
- The requestor presented an order of the Bureau of Emergency Medical Services of the Utah Department of Health. The order sets the rates for ambulance services during the period in which the disputed services were rendered.
- The order details a fee schedule under which a payment for the disputed services can be calculated.
- While the administrative rules of the Utah Department of Health are not applicable to the services in this fee dispute, the methodology may be considered by the Division as the requestor’s evidence that the payment amount sought by the requestor is a fair and reasonable rate of reimbursement in accordance with §134.1.
- It is persuasive that the rates have been determined by the Bureau of Emergency Medical Services of the state of Utah to be appropriate for reimbursement of emergency medical services in that state. This information has not been controverted by the respondent. The Division therefore finds this to be a strong indication that the proposed rates are fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
- In that the rates are standardized for all emergency services in the state of Utah, the Division finds that the proposed rates would 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.
- It also supports that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The submitted documentation supports that the amount sought is based on published values assigned for services involving similar work and resource commitments.
- The Division finds that the requested reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is supported. The Division notes that it has reviewed all of the documentation submitted by the requestor and the respondent(s). Even though some evidence may not have been discussed, all of it was considered. After thorough review of all the information submitted for consideration by the parties in this dispute, the Division concludes that the requestor has discussed, demonstrated, and justified, by a preponderance of the evidence, that the payment amount sought is a fair and reasonable rate of reimbursement for the disputed services.

5. Because the requestor has met its burden to prove that the amount it is seeking is a fair and reasonable rate of reimbursement, the Division now reviews the information presented by the respondent to support that the amount that it paid during the medical billing process is a fair and reasonable rate of reimbursement for the disputed services.

28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V), effective May 25, 2008, 33 *Texas Register* 3954, requires the respondent to provide “documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 of this title if the dispute involves health care for which the Division has not established a MAR, as applicable.”

Review of the submitted documentation finds that:

- The respondent’s position statement asserts that “The carrier’s position remains consistent with its EOBs.”
- The explanations of benefits indicate that the services were paid per workers’ compensation state fee schedule.

- As stated above, the Division has not established a fee schedule for ambulance transportation services. Reimbursement is made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f).
- The respondent did not discuss, explain or present documentation to support how the amount the insurance carrier paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1.
- The respondent did not support that the amount paid represents a fair and reasonable reimbursement for the services in dispute.
- The respondent did not support that the amount paid satisfies the requirements of 28 Texas Administrative Code §134.1.

The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V).

6. The Division finds, by a preponderance of the evidence, that the documentation submitted in support of the reimbursement amount proposed by the requestor is the best evidence of an amount that will achieve a fair and reasonable reimbursement for the services in this dispute. Reimbursement is calculated as follows: Documentation supports paramedic ambulance transport involving advanced life support of an intermediate level. Per the proposed fee schedule, the base rate for this service is \$821.15 per transport. Additionally a payment for inter-local paramedic service agreement fee is supported of \$217.70 per transport. The standard mileage rate is \$31.40 per mile or fraction thereof. Documentation supports 32 billable miles, for a total mileage payment of \$1,004.80. Documentation supports an emergency surcharge of \$39.75. The services took place between the hours of 8:00 p.m. and 8:00 a.m., therefore a night surcharge is supported in the amount of \$39.75. Per the proposed fee schedule, an ambulance shall provide 15 minutes of time at no charge at both point of pickup and point of delivery, and may charge \$22.05 per quarter hour or fraction thereof thereafter. Documentation supports 67 minutes from time of pickup to time back in service. This amount less 30 minutes results in a billable 3 quarters of an hour for a total of \$66.15. The total is \$2,189.30. The insurance carrier paid \$1,495.40, leaving an amount due to the requestor of \$693.90. The requestor is seeking \$673.00. This amount is recommended.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division is to adjudicate the payment, given the relevant statutory provisions and Division rules. The Division would like to emphasize that the outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent. Even though all the evidence was not discussed, it was considered.

The applicable rule for determining reimbursement of the disputed ambulance services is 28 Texas Administrative Code §134.1 regarding a fair and reasonable reimbursement. The evidence provided by the requestor in this case has been found to be persuasive. In turn, the evidence provided by the respondent was not found to be persuasive. Consequently, the Division concludes that the requestor has established by a preponderance of the evidence that additional reimbursement is due. As a result, the amount ordered is \$673.00.

***ORDER***

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$673.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signatures**

\_\_\_\_\_  
Signature

Grayson Richardson  
Medical Fee Dispute Resolution Officer

February 20, 2015  
Date

## **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**