Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RICHARDSON FIRE DEPTARTMENT AMBULANCE

Respondent Name
TRAVELERS INDEMNITY COMPANY OF AMERICA

MFDR Tracking Number
M4-12-2471-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
March 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are seeking our bill to be processed and paid at 100% of the billed charges as there is no workers compensation fee schedule for ambulance services. This was a 911 emergency ambulance transport and we believe the rates we are billing are fair and customary for our region and thus should be paid in full."

Amount in Dispute: $229.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Ambulance services are billed under HCPCS Level II Code A, for example A0429 and A0425 for the services in dispute here. Consequently, Texas has clearly adopted a workers' compensation fee schedule for ambulance services. . . . As such, the Carrier properly reimbursed the Provider under the Texas workers' compensation fee schedule set forth in Rule 134.203, and the Provider is not entitled to full billed charges."

Response Submitted by: The Travelers Companies, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2011	Ambulance Transportation Services	$229.54	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the medical fee guidelines for professional medical services.
4. Texas Labor Code §413.011 sets out provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
   - Z12F – AFTER CAREFULLY REVIEWING THE RESUBMITTED INVOICE, ADDITIONAL REIMBURSEMENT IS NOT JUSTIFIED.

Issues

1. Has the Division established a medical fee guideline for ambulance transportation services?
2. How is reimbursement for ambulance transportation services established in Texas Workers' Compensation?
3. Has the requestor justified that the payment amount sought is a fair and reasonable rate of reimbursement?

Findings

1. The services in dispute are ambulance transportation services billed with procedure codes A0427 – Ambulance service, advanced life support, emergency transport; and A0425 – Ground mileage, per statute mile. The respondent asserts that "Ambulance services are billed under HCPCS Level II Code A, for example A0429 and A0425 for the services in dispute here. Consequently, Texas has clearly adopted a workers' compensation fee schedule for ambulance services." No documentation was found to support that the Division has adopted a workers' compensation fee schedule for ambulance transportation services.

   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 transportation 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 (HPCS) 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 respondent has failed to support its assertion that 28 Texas Administrative Code §134.203(d)(1) is the applicable fee guideline for determining reimbursement of the disputed services. The Division concludes that the reimbursement provisions of §134.203 are not applicable to the ambulance transportation services.

2. 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.

3. Reimbursement for the disputed ambulance services is subject to the provisions of 28 Texas Administrative Code §134.1(f), which 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 "This was a 911 emergency ambulance transport and we believe the rates we are billing are fair and customary for our region and thus should be paid in full."
   - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269). While an ambulance transportation service provider is not a hospital, the above principle is of similar concern in the present case. A health care provider's usual and customary charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services.

Payment of the "full billed charges" is not acceptable when it leaves the ultimate reimbursement in the control of the health care provider—which would ignore the objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. Therefore, the use of a health care provider's "customary" charges cannot be favorably considered unless other data or documentation is submitted to support that the payment amount sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not explain or submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. After thorough review of all the information submitted for consideration by the parties in this dispute, the Division concludes that the requestor has failed to discuss, demonstrate, and justify that the payment amount sought is a fair and reasonable rate of reimbursement for the disputed services.

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. For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 20, 2015
Signature	Medical Fee Dispute Resolution Officer	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.