TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Scott & White EMS Inc.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-25-0536-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 22, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 14, 2023	A0428 and A0425	$801.34	$0.00

Requestor's Position

"This claim has underpaid. First, Ambulance is NOT on the Texas WC Fee schedule. On your remit you refer to 28 TAC 13.203[*sic*] which applied to air ambulance and NOT ground, and the Travis Cty Court case was also involving an air ambulance. We are not a contracted provider with you and unless you provide the methodology that you used to pay this claim, it needs paid in full."

Amount in Dispute: $801.34

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 - Guidelines for Medical Services, Charges and Payments."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §133.240 sets out the requirements for medical payments and denials.
5. 28 TAC §133.20 sets out the medical bill submission procedures for health care providers.
6. 28 TAC §102.4 sets out the general rules for non-Division communications.
7. 28 TAC §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
8. 28 TAC §134.1 sets out general provisions regarding medical reimbursement.

Denial Reasons

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

- A14 – Amb Reimb. is based on the 28 tac 134.203 and Travis Cty. court d-1-gn -15-004940 final judgment holding no pymts > 125% of Medicare are due.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-P5 – Based on payer reasonable and customary fees. no maximum allowable defined by legislated fee arrangement.
- CAC-W, 350 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- DC3, DC4 – Additional reimbursement allowed after reconsideration. for information call (888) 532-5246.
- 426 – Reimbursed to fair and reasonable.
- 920 – Reimbursement is being allowed based upon a dispute.

Issues

1. Has the insurance carrier issued a supplemental payment after the submission of the medical fee dispute?
2. Are the reasons for the insurance carrier's denial supported?
3. Is the requestor eligible for reimbursement?

Findings

1. The requestor seeks reimbursement for HCPCS codes A0428-HH and A0425-HH, rendered on December 14, 2023. A review of the insurance carrier's response finds that a supplemental payment in the amount of $95.41 was issued for HCPCs code A0425 rendered on December 14, 2023. In addition, the insurance issued a payment amount of $4.70 for interest due.

2. This dispute concerns the reduced payment for ground ambulance transportation services, billed under HCPCS codes A0428-HH and A0425-HH.

   The requestor states, "Fair and reasonable examples related to ground claim not provided nor was methodology. We are not contracted with Texas Mutual, and we cannot bill patient, claim is to be paid in full."

   It's important to note that ambulance ground transportation services do not have a fee schedule established under the Medicare Physician Fee Schedule. A review of the information provided reveals that there is no evidence to support a negotiated contract or that the services were rendered via a workers' compensation health care network.

   Payment is therefore subject to the general medical reimbursement provisions of 28 TAC §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 Rule §134.1(f).

   28 TAC §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.

   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. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

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

In the following dispute, the submitted information is examined to determine which party presents the best evidence to support a payment that achieves a fair and reasonable reimbursement for the services in dispute.

The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence. DWC first considers whether the requestor has met the burden to support that the payment amount requested is a fair and reasonable rate of reimbursement for the services in dispute. If the requestor's evidence is persuasive, DWC will then review the evidence presented by the respondent.

- The requestor seeks full payment of the billed charges for HCPCS codes A0428-HH and A0425-HH.
- The requestor did not explain or provide documentation to support how an additional payment of $801.34 ensures quality medical care to injured workers.
- The requestor did not explain or provide sufficient documentation to support an additional payment of $801.34 achieves effective medical cost control.
- The requestor did not explain or provide sufficient documentation to support an additional payment of $801.34 ensures that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not explain or provide sufficient documentation to support that the proposed methodology is consistent with the criteria of Labor Code §413.011.
- The requestor did not explain or provide sufficient documentation to support the idea that the proposed methodology satisfies the requirements of Rule §134.1.

The request for additional reimbursement is not supported. The requestor failed to discuss, demonstrate, and justify by a preponderance of the evidence that the payment sought is a fair and reasonable rate of reimbursement for the services in dispute. Consequently, payment cannot be 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 an additional payment of $801.34 is due.

Order

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

Authorized Signature

		June 13, 2025
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.