



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Acadian Ambulance Svc of Texas

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-25-1380-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

February 20, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 21, 2024	A0428 - Ambulance service, BLS (Basic Life Support) non-emergency transport	\$358.55	\$0.00
February 21, 2024	A0425 - BLS/ALS mileage, per statute mile	\$257.14	\$0.00
Total		\$615.69	\$0.00

Requestor's Position

"At this time Acadian Ambulance requests that our claim be reviewed and reprocessed for additional payment equal to 125% of Medicare rates be paid to AASI."

Amount in Dispute: \$615.69

Respondents' Position

"Texas Mutual on 11/22/2024 received the bill from ACADIAN AMBULANCE SVC OF TEXAS LLC. ...The rationale given by the requestor for the late bill is not consistent with the Rule above. Our position is that no payment is due."

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 \(TAC\) §133.20](#) sets out the procedures for submission of a medical bill.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [TLC §408.0272](#) sets out the exceptions to the timely filing of a medical bill.

Denial Reasons

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

- CO 147 - Contractual Obligations
- M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
- M16 - Please see the letter or bulletin of (dale) Int further information.
- P1 234 – Payor initiated reductions.
- A14 - Amb. Reimb. Is based on the 28 TAC 134.208 and Travis Cty D-1-GN-16-004940 final judgment holding no pymts > 125% of Medicare are due.
- CAC P6 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- CAC 29 – The time limit for filing has expired.
- CAC 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 731 – Per 133.20 (B) provider shall not submit a medical bill later than the 95th day after the date of service.
- CAC W3, 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.
- 004 – No additional reimbursement allowed after reconsideration.
- CAC 138 - Appeal procedure not followed, or time limits not met.
- 879 – Rule 133.250 (B) – Health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

Issues

1. Is the requester entitled to reimbursement for the service(s) in dispute?

Findings

1. The requester is seeking reimbursement in the amount of \$615.69, for ambulance services, rendered on February 21, 2024.

With a few exceptions, 28 TAC §133.20 (b) requires submission of medical bills not later than 95 days from the date of service. TLC §408.0272 (b) provided the exceptions to this requirement, which include:

- The health care provider filed the bill to
 - an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured
 - a health maintenance organization that issues evidence of coverage under which the injured employee is a covered enrollee; or
 - a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
- the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

TLC §408.0272 (d) also states that the period for submitting a claim for payment may be extended by the agreement of the parties.

A review of the medical documentation finds there is insufficient evidence to support that the requester submitted the medical bill to the workers' insurance compensation carrier within 95 days after the notification from the private health insurer. As a result, the DWC finds that the bill(s) in question did not qualify for one of the allowed exceptions, or that an agreement had been reached with the insurance carrier to extend the time limit for filing the medical bills.

DWC finds that the requester is not entitled to reimbursement for the services in question.

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 requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 31, 2025
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 three 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 tres o correo electrónico CompConnection@tdi.texas.gov.