



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Acadian Ambulance Svc of Texas

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-25-1416-01

Carrier's Austin Representative

Box Number 45

DWC Date Received

February 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 17, 2024	A0427 - Ambulance service, ALS, emergency transport, Level 1	\$634.58	\$0.00
June 17, 2024	A0425 - BLS/ALS mileage, per statute mile	\$413.66	\$0.00
Total		\$1,048.24	\$0.00

Requestor's Position

"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-State Office of Risk Management."

Amount in Dispute: \$1,048.24

Respondent's Position

"To date, the Office has not received sufficient evidence to support the exceptions outlined in Labor Code §408.0272 for the waiver of timely filing."

Response Submitted by: State Office of Risk Management

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:

- 29 - The time limit for filing has expired.
- W3 - Reporting purposes only.
- 193 - Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 18 - Exact duplicate claim/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 \$1,048.24, for ambulance services, rendered on June 17, 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.

The DWC finds there is insufficient evidence that the requester submitted the medical bill to the workers compensation insurance carrier within 95 days from the notification of this service being a workers compensation claim. There was insufficient evidence that the bill(s) in question qualified 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 service 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
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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.