



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

PHI AIR MEDICAL

Respondent Name

TRAVELERS CASUALTY INSURANCE CO. OF AMERICA

MFDR Tracking Number

M4-13-1840-02

Carrier's Austin Representative

Box Number 05

MFDR Date Received

March 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Department of Insurance Division of Workers' Compensation does not have a 'fee schedule' for air ambulance services. . . . It is PHI Air Medical's contention that an MAR would not apply to air transportation. Therefore reimbursement should have been made subject to PHI Air Medical's usual and customary charge. . . . PHI Air Medical Charges are fair and reasonable and consistent with the Department of Labor's definition of usual and customary. . . . PHI Air Medical is extensively regulated by the Federal Aviation Administration under the Federal Aviations Act. That act was amended by the Airline Deregulation Act 49 U.S.C. Section 41713 (the 'ADA') in 1978 in order to impose a single federal regulatory scheme on air carrier thereby precluding state regulation of rates and routes."

Requestor's Position Summary dated June 6, 2014: "if the Division continues to apply the Texas statute in contravention of the ADA, both statute and rules require application of the 'fair and reasonable' standard. . . . The Airline Deregulation Act ("ADA") imposes a single federal regulatory scheme on air carriers that precludes state regulation of rates and certain other issues"

Requestor's Position Summary dated July 8, 2014: "The air ambulance providers have submitted documentation demonstrating that their market-driven charges represent the cost of doing business, plus a very modest profit margin . . . The Statute and Rules Do Not Allow for Default-to-Medicare Reimbursement"

Amount in Dispute: \$18,523.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reviewed the billing and reimbursed the Provider at the Medicare rate relevant to these services. . . . Under the Deregulation Act cited above, only the federal government may set rates for air ambulance carriers. . . . the FAA has delegated the responsibility for setting the reimbursement rates for air ambulance services to the Centers for Medicare/Medicaid Services when services. . . . As Texas has adopted by statute the Medicare reimbursement methodology as the basis for reimbursement of medical services in Texas, including a fee schedule covering air ambulance services, the Medicare air ambulance reimbursement rates should apply. . . . reimbursement should be calculated under the federal reimbursement regulations at the lesser of billed charges or the Medicare fee schedule rate for the air ambulance services rendered."

Response Submitted by: Travelers

## **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2012	Air Ambulance Services	\$18,523.04	\$18,523.04

## **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 out general provisions regarding medical reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. Former 28 Texas Administrative Code §134.202 sets out the guideline for such services before March 1, 2008.
5. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and guidelines.
6. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
  - TXS2 – AMBULANCE SERVICES ARE REIMBURSED AT 125% ABOVE THE CM FEE SCHEDULE AMOUNT FOR THE TYPE OF SERVICE AND LOCALITY.
  - T263 – AIR AMBULANCE CARRIER SERVICES ARE REIMBURSED BASED ON THE MEDICARE FEE SCHEDULE WHICH IS THE LESSER OF BILLED CHARGES OR THE MEDICARE FEE SCHEDULE.
  - S2TX – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. AMBULANCE MILEAGE SERVICES ARE REIMBURSED AT 125% ABOVE THE CMS FEE SCHEDULE AMT FOR THE TYPE OF SERVICE, LOCALITY AND NUMBER OF MILES TRAVELED.
  - W4 – NO ADDITIONAL PAYMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
  - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
  - Z001 – FOR EXPLANATION OF A NON-PAYMENT BY THE ADJUSTER, PLEASE CONTACT THE ADJUSTER ON FILE.

### **Issues**

1. Does the Federal Aviation Act preempt the authority of the Texas Labor Code to regulate air ambulance fees?
2. Should air ambulance services be reimbursed according to the Medicare ambulance fee schedule?
3. Is there an applicable fee guideline for air ambulance services?
4. What is the applicable rule for determining reimbursement of the disputed air ambulance services?
5. Has the requestor justified that the payment amount sought is a fair and reasonable rate of reimbursement?
6. Has the respondent justified that the payment made is a fair and reasonable rate of reimbursement?
7. Is additional reimbursement due?

### **Findings**

1. The requestor maintains that the Federal Aviation Act, as amended by the Airline Deregulation Act of 1978, 49 U.S.C. §41713, preempts the authority of the Texas Labor Code to apply the Division's medical fee guidelines to air ambulance services. This threshold legal issue was considered by the State Office of Administrative Hearings (SOAH) in *PHI Air Medical v. Texas Mutual Insurance Company, et al.*, Docket number 454-12-7770.M4, which held that "the Airline Deregulation Act does not preempt state worker's compensation rules and guidelines that establish the reimbursement allowed for the air ambulance services . . . rendered to injured workers (claimants)." In particular, SOAH found that:

the McCarran-Ferguson Act explicitly reserves the regulation of insurance to the states and provides that any federal law that infringes upon that regulation is preempted by the state insurance laws, unless the federal law specifically relates to the business of insurance. In this case, there is little doubt that the worker's compensation system adopted in Texas is directly related to the business of insurance . . .

The Division agrees. Based on SOAH's threshold issue discussion and the information provided by the parties in this dispute, the Division concludes that its jurisdiction to consider the medical fee issues is not preempted by the Federal Aviation Act or the Airline Deregulation Act of 1978. The disputed services will therefore be reviewed pursuant to Texas Labor Code §413.031 and applicable Division rules.

2. The health care provider rendered air ambulance services, billed under procedure codes A0431 and A0436, that are not addressed in the *Medical Fee Guideline for Professional Services* as set forth in 28 Texas Administrative Code §134.203. The insurance carrier reduced payment for these services with claim adjustment reason code T263 – "AIR AMBULANCE CARRIER SERVICES ARE REIMBURSED BASED ON THE MEDICARE FEE SCHEDULE WHICH IS THE LESSER OF BILLED CHARGES OR THE MEDICARE FEE SCHEDULE."

The respondent argues that:

The Carrier reviewed the billing and reimbursed the Provider at the Medicare rate relevant to these services. . . . Under the Deregulation Act cited above, only the federal government may set rates for air ambulance carriers. . . . the FAA has delegated the responsibility for setting the reimbursement rates for air ambulance services to the Centers for Medicare/Medicaid Services when services. . . . As Texas has adopted by statute the Medicare reimbursement methodology as the basis for reimbursement of medical services in Texas, including a fee schedule covering air ambulance services, the Medicare air ambulance reimbursement rates should apply. . . . reimbursement should be calculated under the federal reimbursement regulations at the *lesser of* billed charges or the Medicare fee schedule rate for the air ambulance services rendered.

Review of the submitted information finds no documentation to support that the FAA has delegated the responsibility for setting reimbursement rates for the disputed services to the Centers for Medicare and Medicaid Services.

As stated above, the Division has found that its authority to consider the medical fee issues in this dispute is not preempted by the Federal Aviation Act, or the Airline Deregulation Act of 1978; therefore, this dispute is decided pursuant to the Texas Labor Code and all applicable Division rules.

The Legislature has expressly prohibited the use of *unmodified* Medicare rates in Texas Labor Code §413.011(b), which states that:

In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d) . . . This section **does not adopt the Medicare fee schedule** [emphasis added], and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.

Therefore, the respondent's contention that the payment standard to apply is the *unmodified* Medicare rate does not meet the requirements of Labor Code §413.011(b).

3. The insurance carrier reduced payment for these services with claim adjustment reason codes: W1 – "WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT"; TXS2 – "AMBULANCE SERVICES ARE REIMBURSED AT 125% ABOVE THE CM FEE SCHEDULE AMOUNT FOR THE TYPE OF SERVICE AND LOCALITY."; and S2TX – "W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. AMBULANCE MILEAGE SERVICES ARE REIMBURSED AT 125% ABOVE THE CMS FEE SCHEDULE AMT FOR THE TYPE OF SERVICE, LOCALITY AND NUMBER OF MILES TRAVELED." No documentation was found to support that the services are subject to a negotiated contract. The submitted documentation did not support that there is a specific Texas fee schedule or medical fee guideline applicable to the disputed air ambulance services.

The respondent asserts, "Texas has adopted by statute the Medicare reimbursement methodology as the basis for reimbursement of medical services in Texas, including a fee schedule covering air ambulance services."

While the Division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203 adopts Medicare payment policies with respect to reimbursement of the professional medical services to which the rule is applicable, no documentation was presented to support that air ambulance services are covered by the rule.

Moreover, subsections (b) and (c) of 28 Texas Administrative Code §134.203 must be read as part of and in context with the entire rule. Administrative rules are interpreted in the same manner as statutes; see *Rodriguez v. Service Lloyds Insurance Company*, 997 South Western Reporter Second 248, 254 (Texas 1999). Therefore, like a statute, the rule must be considered in its entirety; single subsections may not be read in isolation. See also *Continental Casualty Insurance Company v. Functional Restoration Associates, et al.*, 19 South Western Reporter Third 393, 398 (Texas 2000).

Subsection (b) of Rule 134.203 contains general provisions for reimbursement of professional medical services while subsections (c), (d), and (e) address how professional services, durable medical equipment, and clinical laboratory services respectively shall be reimbursed. Air ambulance transport services are not listed under subsections (c), (d) or (e), and are simply not included in the categories of services discussed.

The Division notes that the *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, is not applicable to ambulance services. Per §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:

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 subparagraphs 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 paragraph (d)(1) nor (d)(2) can be construed as applicable to the ambulance services in dispute. That is, the maximum reimbursement amounts and methods listed in paragraphs (d)(1) and (d)(2) are applicable only to items billed using HCPCS Level II codes which are also durable medical equipment, prosthetics, orthotics or

supplies listed in the referenced Medicare DMEPOS fee schedule (or comparable Medicaid fee schedule for DME and medical supplies). Further, paragraphs (d)(1) and (d)(2) are intended to be read together, as the “published Medicare rate” language in paragraph (d)(2) refers *exclusively* to items listed in Medicare’s DMEPOS fee schedule.

Even if subsection (d) were found not to apply solely to DMEPOS services, subparagraph (d)(2) would *still* not apply to ambulance services because there *are* published Medicare rates for ambulance services, even though *those* rates are not included in the specific Medicare fee schedule referenced in (d)(1). Thus, at most, subparagraph (d)(3) would apply and implicate fair and reasonable reimbursement pursuant to §134.203(f) and 28 Texas Administrative Code §134.1.

The respondent’s position that the Division has adopted a fee schedule covering air ambulance services is not supported. The Division finds that air ambulance services were not contemplated in the formulation of §134.203 and the rule does not apply to the services in dispute. The Division concludes that there is no applicable fee guideline for air ambulance services. Accordingly, reimbursement is determined under the general medical reimbursement provisions of 28 Texas Administrative Code §134.1 regarding a fair and reasonable reimbursement.

4. The general medical reimbursement provisions of 28 Texas Administrative Code §134.1 require 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).

As stated above, the Division has concluded there is no applicable fee guideline for air ambulance services. No documentation was found to support a negotiated contract. Therefore, §134.1(e)(3) requires that reimbursement be made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f). The Division finds that §134.1(f) is the applicable rule for determining reimbursement of the air ambulance services in this dispute.

5. In the following analysis, the positions of both parties and the evidence presented to support each party’s proposed reimbursement are examined to determine which party presents the best evidence of a payment that will achieve a fair and reasonable reimbursement for the air ambulance services in dispute. The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

28 Texas Administrative Code §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 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 104 (Texas Appeals – Austin 2003, petition for review denied), that “each . . . 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. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

28 Texas Administrative Code §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 . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

Review of the submitted documentation finds that:

- The requestor asserts that: “reimbursement should have been made subject to PHI Air Medical’s usual and customary charge.”
- 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 air ambulance company 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 “usual and customary” 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 “usual and customary” charges cannot be favorably considered unless other data or documentation is submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- In the present dispute, however, the requestor has submitted additional documentation and data to support that the payment amount sought is a fair and reasonable reimbursement for the services in this dispute.
- The requestor asserts that the amount requested is designed to ensure the quality of medical care:

The Division has long construed this inquiry as one of patient access . . . To ensure patient access to emergency helicopter service, it is essential that air ambulance providers are reimbursed a sufficient amount to cover the costs of providing the service to patients. This amount is reflected in their usual and customary market rates.
- In support of the quality of medical care, the requestor submitted documentation of a study as described in an article of the *Journal of the American Medical Association*, volume 249, number 22 (1983), “The Impact of a Rotorcraft Aeromedical Emergency Care Service on Trauma Mortality,” by William G. Baxt, and Peggy Moody, which reported a “52% reduction in predicted mortality of the aeromedical group” in reviewing populations of trauma patients transported to a trauma center by standard land prehospital care services as compared to the same trauma center by a rotorcraft aeromedical service.
- Additionally the requestor submitted documentation of a study as described in an article of the *Journal of the American Medical Association*, volume 307, number 15 (2012), “Association Between Helicopter vs. Ground Emergency Medical Services and Survival for Adults With Major Trauma,” by Samuel M. Galvagno, Jr., DO, PhD; et al., which the requestor asserts “indicate that helicopter EMS transport is independently associated with improved odds of survival for seriously injured adults.”
- The requestor’s July 8th position statement asserts that the amount requested achieves medical cost control: “Providers cannot and do not arbitrarily raise their rates to achieve higher profit margins, as evidenced by CMS data reflecting minimal variation in provider’s billed charges in both statewide and national figures.”
- The requestor further states:

Providers’ Financial Data and the CMS Study Prove that the Billed Charges are Constrained by Market Forces . . . the air ambulance charge model achieves effective cost control because it does not reflect the type of high historical profit margins that would indicate a provider’s ability to raise rates to an unfair or unsustainable level. . . . The air ambulance provider’s market-driven price inflexibility is further strengthened by the national study published by CMS . . . CMS published provider charge data from every Texas provider and reported the average billed charges, along with the 25th percentile, 75th percentile, maximum submitted charge amounts and minimum submitted charges. Not only are the air ambulance charges similar across the Texas, they are also relatively consistent across the

country. While variations volume and payor mix in different parts of the state and country necessitate slight disparities in charges, the lack of wide fluctuations in pricing prove that providers cannot and do not deviate from their usual and customary, market-driven charges.

- The requestor asserts that the amount requested does 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, stating “these providers apply usual and customary charges to all patients regardless of payor-type or standard of living, and expect payment in full except where prohibited by federal law.”
- The requestor submitted documentation of the provider’s revenue, expenses, and profit margins after estimated income tax for calendar years 2010 through 2013 respectively. The data supports that their profit margins were lower than 1% for 2011, and lower than 6% for all years; except for 2012, for which their margin was lower than 12%.
- The requestor states, “This proves that the air ambulance charge model achieves effective cost control because it does not reflect the type of high historical profit margins that would indicate a provider’s ability to raise rates to an unfair or unsustainable level.”
- The requestor states:

Unlike hospitals, air ambulance providers (1) rarely, if ever, enter into discounted contracts with private insurance companies; (2) have not artificially inflated their billed charges to enable them to offer discounts to the insurance companies while maintaining the ability to recover their costs; and (3) routinely seek to balance bill the patient who is left with the remainder of the usual and customary charges that are not paid in full by a third-party payor.
- The requestor asserts that the amount requested accounts for the increased security of Workers’ Compensation payment, stating “In the air ambulance context, limiting collections to any artificially-reduced rate is unreasonable because these providers consistently rely on collecting 100 percent of their billed charges from all patients except where prohibited by federal law.”
- The requestor further asserts that the amount requested ensures that similar procedures provided in similar circumstances receive similar reimbursement:

air ambulance providers charge the same rates for all patients, regardless of payor-type or economic status. . . . the Division clearly noted when it reasoned, ‘the objectives of the 1996 MFG were to move Texas MFG reimbursements toward a median position in comparison with other states, away from a charge-based structure [as applied by hospitals], and more toward a market-based system.’ An air ambulance provider’s usual and customary market rates are the only charges that achieve this result.
- The requestor asserts that the amount requested is based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments.
- The requestor’s Exhibit 11 presents documentation of the aggregated national charge range data by HCPCS code, as compiled by CMS from all claims submitted to Medicare in calendar year 2012, to support that the requestor’s billed charges are consistent with national averages. The aggregate charges for A0431 Rotary wing air transportation ranged from a minimum of \$4,840.00 to a maximum of \$26,691.09. The provider’s charge of \$16,075.00 for the service in this dispute falls within the range of comparable charges. The aggregate charges for A0436 Rotary wing air mileage ranged from a low of \$49.50 to a high of \$252.24 per mile. The provider’s charge of \$209.00 per mile falls within the range of data presented by the requestor to support that the amount charged for the services are not in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living.
- The Division finds that for the services in this dispute, the requested reimbursement meets the criteria of ensuring the quality of medical care, controlling medical costs, not providing a payment in excess of the fee charged for similar treatment paid by an injured individual of an equivalent standard of living or by someone acting on that individual's behalf, taking into consideration the increased security of payment afforded by the labor code, and ensuring that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor has explained and supported that the requested reimbursement satisfies the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is supported. After thorough review of the submitted information, 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 air ambulance services in dispute.

6. Because the requestor has met the burden to show that the amount sought is a fair and reasonable rate of reimbursement, the Division now reviews the information presented by the respondent to support whether the amount paid is a fair and reasonable rate of reimbursement for the services in dispute.

28 Texas Administrative Code §133.307(d)(2)(E)(v), effective May 31, 2012, 37 *Texas Register* 3833, 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 or §134.503 of this title if the dispute involves health care for which the division has not established a MAR or reimbursement rate, as applicable.

Review of the submitted documentation finds that:

- The respondent asserts, “reimbursement should be calculated under the federal reimbursement regulations at the *lesser of* billed charges or the Medicare fee schedule rate for the air ambulance services rendered.”
- As stated above, the Legislature has expressly prohibited the use of *unmodified* Medicare rates in Texas Labor Code §413.011(b), therefore the Division may not consider this method as evidence of a fair and reasonable reimbursement in accordance with Labor Code §413.011.
- No documentation was presented by the respondent to support the insurance carrier’s calculation of the Medicare fee(s) for the services in dispute.
- No documentation was found to support that the insurance carrier’s payment was consistent with its proposed methodology.
- Per 28 Texas Administrative Code §134.1(g), “The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier’s methodology(ies) establishing fair and reasonable reimbursement amounts.” The respondent did not explain or submit documentation to support the insurance carrier’s methodology(ies) establishing fair and reasonable reimbursement amounts for the disputed services in accordance with the requirements of §134.1(g).
- The respondent did not support that the amount paid satisfies the requirements of §134.1(f).
- The respondent did not support that the amount paid represents a fair and reasonable reimbursement for the services in dispute.

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)(E)(v).

7. 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 air ambulance services in this dispute. Reimbursement is calculated as follows: review of the submitted medical bill finds that the total charge for the disputed air ambulance services is \$22,763.00. The Division finds this amount to be a fair and reasonable reimbursement for the air ambulance services in dispute. The total recommended reimbursement is \$22,763.00. The amount previously paid by the insurance carrier is \$3,939.96. The requestor is seeking \$18,523.04. Accordingly, the additional payment amount recommended is \$18,523.04.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care, 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 findings and decision in this dispute are based on the evidence presented by the requestor and respondent. Even though all the evidence was not discussed, it was considered.

The applicable rule for determining reimbursement of the disputed air ambulance services is 28 Texas Administrative Code §134.1 regarding a fair and reasonable reimbursement. The evidence presented by the requestor was found to be persuasive. In turn, the evidence presented by the respondent was not 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 \$18,523.04.

***ORDER***

Based upon 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 \$18,523.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

	Grayson Richardson	November 30, 2015
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 in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request 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 §141.1(d).

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