



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

AIR EVAC EMS, INC.

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-13-3355-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

August 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the United States Code Title 49, 41713, the Airline Deregulation Act (ADA) of 1978 states that individual states cannot regulate the prices, routes or services of the air ambulance industry, therefore, it is inappropriate that air ambulance services be subject to state workers' compensation allowance and should be reimbursed at 100% of billed charges."

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: \$25,778.26

RESPONDENT'S POSITION SUMMARY

Respondent's Initial Position Summary: "the Office has determined that reimbursement has been properly made pursuant to 28 TAC §134.1 . . . for HCPC code A0431 and A0436; including the up-charge of 125% of the Medicare rate. . . . the requestor filed a 'new' submission on 5/23/2013 with additional CPT/HPC codes A0422, 96374, 93041, J3010 and J2405 (Exhibit B). The additions and changes made this submission a 'new' bill, whereas the audit denied the entire bill for 29-Time limit for filing has expired . . . this submission was 'sent' 125 days from the date of service . . . The Office is in full compliance with Division Rules §134.202(b)(c)(2) and 28 TAC §134.1 and finds that no further reimbursement is due to the provider."

Respondent's Position Summary dated June 23, 2015: "SORM properly and correctly reimbursed the providers pursuant to 28 TAC 134.1, for HCPC code A0431 and A0436; including the up-charge of 125% of the Medicare rate. In 2006, the Ambulance Fee Schedule was fully implemented and the amount of Medicare reimburse for air ambulance transports has been adjusted in accordance with the Consumer Price Index each year since and insurance carriers, including SORM have paid 125% of that increased amount. . . . The Division has misinterpreted 134.203(d) to indicate that the ambulance codes are excluded under the rule. But rule 134.203(f) indicates that the rule only applies to 'services for which no relative value unit of payment has been assigned by Medicare.' There is a Medicare relative value unit assigned for HCPCs codes A0431 and A0436. "

Responses submitted by: State Office of Risk Management

## **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2013	Air Ambulance Services	\$25,778.26	\$24,505.84

## **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 §133.20 sets out medical bill submission procedures for health care providers.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services provided on or after March 1, 2008.
5. Former 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services provided on or after September 1, 2002.
6. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
7. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
8. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and guidelines.
9. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.
10. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
  - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
  - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
  - 18 – EXACT DUPLICATE CLAIM/SERVICE.
  - 217 – BASED ON PAYER REASONABLE & CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT. (NOTE: TO BE USED FOR PROPERTY AND CASUALTY ONLY)

### **Issues**

1. Were the disputed services timely submitted to the insurance carrier for consideration of payment?
2. Does the Federal Aviation Act preempt the authority of the Texas Labor Code to regulate air ambulance fees?
3. Is there an applicable fee guideline for air ambulance transportation services?
4. What is the applicable rule for determining reimbursement of the disputed 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 insurance carrier denied disputed procedure codes A0422, 96374, 93041, J3010 and J2405 with claim adjustment reason code 29 – “THE TIME LIMIT FOR FILING HAS EXPIRED.” The insurance carrier asserts that “the requestor filed a ‘new’ submission on 5/23/2013 with additional CPT/HPC codes A0422, 96374, 93041, J3010 and J2405 (Exhibit B). The additions and changes made this submission a ‘new’ bill, whereas the audit denied the entire bill for 29-Time limit for filing has expired . . . this submission was ‘sent’ 125 days from the date of service.”

28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272: “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” No documentation was found to support that any of the exceptions described in Texas Labor

Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill for these services within 95 days from the date the services were provided. Review of the medical bill marked "Corrected Claim" finds that the signature date in box 31 is May 16, 2013. This date is more than 95 days after the disputed service date of January 13, 2013. No documentation was found to support that procedure codes A0422, 96374, 93041, J3010 and J2405 were timely submitted to the insurance carrier for consideration of payment.

Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." The Division concludes that the requestor has not met the requirements of §133.20(b) with respect to these disputed services, and has therefore forfeited the right to reimbursement for the disputed services billed under procedure codes A0422, 96374, 93041, J3010 and J2405.

However, documentation was found to support that procedure codes A0431 and A0436 were timely submitted to the insurance carrier for consideration of payment; therefore, the provider has not forfeited the right to reimbursement for the services billed under these two codes. These disputed services will be reviewed per applicable Division rules and fee guidelines.

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

3. The respondent contends that:

SORM properly and correctly reimbursed the providers pursuant to 28 TAC 134.1, for HCPC code A0431 and A0436; including the up-charge of 125% of the Medicare rate. In 2006, the Ambulance Fee Schedule was fully implemented and the amount of Medicare reimburse for air ambulance transports has been adjusted in accordance with the Consumer Price Index each year since and insurance carriers, including SORM have paid 125% of that increased amount. SORM is in full compliance with Division Rules 134.1(e) and 134.203(d) and finds that no further reimbursement is due to the provider.

The Division has misinterpreted 134.203(d) to indicate that the ambulance codes are excluded under the rule. But rule 134.203(f) indicates that the rule only applies to 'services for which no relative value unit of payment has been assigned by Medicare.' There is a Medicare relative value unit assigned for HCPCs codes A0431 and A0436.

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

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.

However, the services in dispute are air ambulance transportation services for which the Division has not established a medical fee guideline. The Division has not developed or adopted any conversion factors or other payment adjustment factors applicable to air ambulance services, and air ambulance services were not contemplated in the development or adoption of any of the Division's medical fee guidelines.

The Division notes that the *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, is not applicable to ambulance transportation 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 (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 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 transportation services in dispute. That is, the maximum reimbursement amounts and methods listed in paragraphs (d)(1) and (d)(2) are applicable only to items that are both billed using HCPCS Level II codes and which are also durable medical equipment, prosthetics, orthotics or 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 reimbursement for air ambulance transportation services can be determined under the Division's *Medical Fee Guideline for Professional Services*, Rule 134.203, is not supported. The Division finds that air ambulance services were not contemplated in the formulation of that rule and §134.203 does not apply to the services in dispute. The Division further 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 transportation 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 transportation 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 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:

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: “it is inappropriate that air ambulance services be subject to state workers’ compensation allowance and should be reimbursed at 100% of billed charges.”
- 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 “100% of 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 billed 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 that

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.

- Review of the health care provider's billed charges finds that the submitted charges for the services in this dispute are consistent with national aggregate charge range data compiled by CMS as found in the requestor's Exhibit 11.
- 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 further asserts that
  - 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 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, presenting documentation of the aggregated national and statewide charge data by HCPCS code, as compiled by CMS, to support that the requestor's billed charges are consistent with national averages.
- The requestor has explained and supported that the requested reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is supported. The Division notes that it has reviewed all of the documentation submitted by the requestor and the respondent(s). Even though some evidence may not have been discussed, all of it was considered. After thorough review of all the information submitted for consideration by the parties in this dispute, 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 disputed services.

6. Because the requestor has met its burden to prove that the amount it is seeking is a fair and reasonable rate of reimbursement, the Division now reviews the information presented by the respondent to support whether the amount it has 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: "SORM properly and correctly reimbursed the providers pursuant to 28 TAC 134.1, for HCPC code A0431 and A0436; including the up-charge of 125% of the Medicare rate."

- The submitted explanations of benefits do not indicate what method was used to calculate the fee for the disputed services.
- No documentation was presented to support a calculation of the Medicare fees for the disputed services.
- No documentation was presented to support that the reimbursement amount paid by the insurance carrier was calculated “including the up-charge of 125% of the Medicare rate.”
- No documentation was found to support that the insurance carrier’s payment was consistent with its proposed methodology.
- The respondent states: “In 2006, the Ambulance Fee Schedule was fully implemented and the amount of Medicare reimburse for air ambulance transports has been adjusted in accordance with the Consumer Price Index each year since and insurance carriers, including SORM have paid 125% of that increased amount.”
- Review of the submitted information finds no documentation to support that the cost inputs that were determined to be appropriate for air ambulance service providers in 2006 remain appropriate for determining the costs to render air ambulance services on the disputed date of service — taking into account changes in regulatory requirements, changes in required technology, supplies and equipment, changes in medical practice, changes in the requirements for personnel and training, changes in the marketplace, and other economic indicators in health care. Even after adjusting by the Consumer Price Index, the submitted documentation was not found to support that the Medicare payment for air ambulance services is a fair and reasonable rate for the services in this dispute.
- Regardless, as stated above, Labor Code §413.011(b) is explicit that “This section does not adopt the Medicare fee schedule, 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.” Accordingly, the Division next considers the evidence submitted by the respondent to support its proposed payment adjustment factor (PAF) of 125%.
- 28 Texas Administrative Code §134.1(g) requires that “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 present any documentation to support that the insurance carrier employed a PAF of 125% in determining the amount paid for the services in this dispute. No documentation was presented to show how the payment was calculated for the services in this dispute.
- No documentation was found to support the respondent’s proposed 125% PAF.
- No documentation contemporaneous to the medical bill processing date was presented to support that the insurance carrier contemplated a reasoned justification for its proposed 125% payment adjustment factor.
- The Division finds that the insurance carrier has failed to support the proposed payment adjustment factor of 125%. No documentation was presented to support that in determining the appropriate fees, the insurance carrier ever developed its proposed conversion factor through a deliberative process taking into account economic indicators in health care and the requirements of Labor Code §413.011(d) to justify the specified payment adjustment factor of 125%.
- Review of the submitted information finds no documentation to support that the insurance carrier has consistently applied fair and reasonable reimbursement amounts and maintained, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts 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 disputed services billed under procedure codes A0431 and A0436. Reimbursement is calculated as follows: review of the submitted medical bill finds that the total charge for procedure codes A0431 and A0436 is \$34,326.78. The Division finds this amount to be a fair and reasonable reimbursement for the services in this dispute. The amount previously paid by the insurance carrier is \$9,820.94. Accordingly, the additional payment amount recommended is \$24,505.84.

**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 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 requestor has forfeited the right to reimbursement for disputed services billed under procedure codes A0422, 96374, 93041, J3010 and J2405 due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a); however, the disputed services billed under procedure codes A0431 and A0436 are eligible for review. 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 provided by the requestor in this case was found to be persuasive. In turn, the evidence provided 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 \$24,505.84.

**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 \$24,505.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	_____
Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	June 5, 2015 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.**