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
AIR EVAC EMS, INC.

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-14-0880-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 18, 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: $30,158.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Respondent paid Requestor 125% of the Medicare air ambulance fee schedule in accordance with the Texas law Requestor has invoked. Requestor does not assert those calculations are incorrect."

Response Submitted by: Flahive, Ogden & Latson

Respondent's Position Summary dated November 18, 2014: "The Division dutifully covered all the bases for reimbursement of HCPCS level II, A Codes in Rule 134.203(d)(1) and (2), applying Medicare or Texas Medicaid fee schedules. And as to air ambulance reimbursement, both Medicare and Texas Medicaid have such fee schedules. Rule 134.203(d) unambiguously states all HCPCS Level II, A Codes are covered by the Rule. . . . While Respondent believes that, as HCPCS Level II, A Codes, air and ground ambulance services are covered by Rule 134.203(d)(1) or (2), the Respondent Carriers would show that 125% of Medicare or Texas Medicaid satisfies the requirements of 'fair and reasonable' reimbursement in accordance with Labor Code § 413.011 and Rule 134.1."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2013	Air Ambulance Services	$30,158.97	$29,769.59

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. 25 Texas Administrative Code §157.12 sets out emergency medical services provider license requirements regarding rotor-wing air ambulance operations.
6. 25 Texas Administrative Code §157.36 establishes criteria for denial and disciplinary actions for EMS personnel and applicants for a certificate or license.
7. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and guidelines.
8. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.
9. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - W1 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 18 – EXACT DUPLICATE CLAIM/SERVICE.

Issues

1. Does the Federal Aviation Act preempt the authority of the Texas Labor Code to regulate air ambulance fees?
2. What is the reimbursement for the disputed professional medical services?
3. Is there an applicable fee guideline for air ambulance services?
4. What is the applicable rule for determining reimbursement of 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. This dispute relates, in part, to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

> To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . .
>
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The applicable Division conversion factor for calendar year 2013 is $55.30. Reimbursement is calculated as follows:

- Procedure code 96374 represents intravenous push injection, a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.18. The practice expense (PE) RVU of 1.48 multiplied by the PE GPCI of 0.912 is 1.34976. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.809 is 0.02427. The sum of 1.55403 is multiplied by the Division conversion factor of $55.30 for a MAR of $85.94. The provider billed 3 units. The definition of this code is for a single, initial injection. Subsequent or concurrent injections of the same or additional substances must be billed with different codes. Only one unit is supported; payment for any additional units is not recommended. The recommended reimbursement is $85.94.

- Procedure code J3010 represents fentanyl citrate injection. This code has a status indicator of E, which denotes codes that are excluded from the Medicare Physician Fee Schedule by regulation. This code is not assigned a relative value or payment amount. Per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement. The insurance carrier allowed $0.73. The requestor did not discuss or submit documentation to support a fair and reasonable reimbursement for the fentanyl citrate injection. Review of the submitted information finds insufficient documentation to support a different payment amount from that determined by the insurance carrier.

- Procedure code J2405 represents ondansetron HCl injection. This code has a status indicator of E, which denotes codes that are excluded from the Medicare Physician Fee Schedule by regulation. This code is not assigned a relative value or payment amount. Per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement. The insurance carrier allowed $0.20. The requestor did not discuss or submit documentation to support a fair and reasonable reimbursement for the ondansetron HCl injection. Review of the submitted information finds insufficient documentation to support a different payment amount from that determined by the insurance carrier.

- Procedure code J2270 represents morphine sulfate injection. This code has a status indicator of E, which denotes codes that are excluded from the Medicare Physician Fee Schedule by regulation. This code is not assigned a relative value or payment amount. Per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement. The insurance carrier allowed $5.98. The requestor did not discuss or submit documentation to support a fair and reasonable reimbursement for the morphine sulfate injection. Review of the submitted information finds insufficient documentation to support a different payment amount from that determined by the insurance carrier.

3. Additionally, the health care provider rendered air ambulance services, billed under procedure codes A0422, A0394, 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 respondent contends that "The Division dutifully covered all the bases for reimbursement of HCPCS level II, A Codes in Rule 134.203(d)(1) and (2), applying Medicare or Texas Medicaid fee schedules. And as to air ambulance reimbursement, both Medicare and Texas Medicaid have such fee schedules. Rule 134.203(d) unambiguously states all HCPCS Level II; A Codes are covered by the Rule."

   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 respondent contends that "And even if the Medicare fee schedule under Rule 134.203(d)(1) is not applicable, then the Texas Medicaid fee schedule under Rule 134.203(d)(2) would be applicable"; however, as above, this rule may not be interpreted to include Medicaid fee schedules that are not specified in §134.203(d)(2). Paragraph (d)(2) refers specifically to the "Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS." This Medicaid fee schedule does not address ambulance services. Again, all requirements must be met for a service to be payable at 125% of the Medicaid DME/medical supplies rate. As ambulance services are not supplies or durable medical equipment, and are not found in the referenced Medicaid fee schedule, §134.203(d)(2) cannot be arbitrarily applied to services that do not meet the criteria. Moreover, the rule cannot be interpreted to include Medicaid fee schedules beyond the Medicaid fee schedule for DME and medical supplies.

   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 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 reimbursement for air ambulance 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 concludes that there is no applicable fee guideline for air ambulance services. Accordingly, reimbursement for the disputed air ambulance procedure codes 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 states:

  > Applying the ‘Fair and Reasonable’ Standards in the Air Ambulance Context, An Air ambulance’s Market-Driven Usual and Customary Market-Driven Charges Are the Only Available Fair Reasonable Reimbursement. . . . the air ambulance provider’s usual and customary market-driven rates satisfy the statutory requirements designed to ensure access, quality, outcomes, utilization and cost . . .

- 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 a provider’s “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 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 Declaration of Jeff Frazier, submitted on behalf of the respondent, makes a general assertion that "Air ambulance service providers request reimbursement far out of proportion to their operating costs." The Division agrees with the general proposition that a fair and reasonable rate cannot be based on unreasonable expenses or profits; however, the respondent fails to demonstrate if or in what manner Mr. Frazier's assertion applies to the requestor or the services that are the subject of this medical fee dispute.
- 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 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 form 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 $18,750.00 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 $166.86 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 methodology would satisfy 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: "The application of the 125% Payment Adjustment Factor to Medicare or Texas Medicaid air ambulance rates produces fair and reasonable reimbursement in compliance with Labor Code § 413.011 and Rule 134.1."
   - The method by which the insurance carrier calculated the amount paid for the disputed services is not specified or explained in the submitted explanations of benefits.
   - No documentation was submitted to explain or support the insurance carrier's calculation of the payment for the services in this dispute.
   - The respondent did not submit documentation to support its calculation of the Medicare fees for the services in dispute.
   - No documentation was presented to support that the reimbursement amount paid by the insurance carrier was calculated according to a 125% payment adjustment factor applied to the Medicare or Texas Medicaid air ambulance rates.
   - No documentation was found to support that the insurance carrier's payment was consistent with its proposed methodology.
   - The respondent presents expert testimony from Ronald T. Luke, who states in paragraph 7.d of his affidavit, "The Medicare rates are based on the Centers for Medicare and Medicaid Services' (CMS) 1998 analysis of the costs of providing RWAA services, and a negotiated ratemaking process between CMS and RWAA providers. CMS updates the rates annually."

- 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 1998 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 annual rate of inflation factor, as calculated by the Bureau of Labor Statistics Consumer Price Index – US City Average for Urban Consumers, and other Congressional direction to CMS (Luke Affidavit, page 16, paragraph 40), 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%.
- The respondent's expert, Mr. Luke, acknowledges in his affidavit (paragraph 7.e.) that "the annual CMS updates for the RWAA Medicare rates do not match the annual increases in the cost of goods and services needed to provide RWAA services."
- Mr. Luke further states:

  > In order to account more fully than CMS does for inflation in the expenses of RWAA providers since 1998, the Division could properly, as it has done in other contexts, apply PAFs to the Medicare trip and mileage rates. I have developed the necessary PAFs for the trip rate and for the mileage rate for each year. For example, the 2014 PAF to account for RWAA inflation since 1998 for the trip rate is 118.8%. The 2014 PAF to account for RWAA inflation since 1998 for the mileage rate is 109.8%.

- The 118.8% and 109.8% PAFs assume that the 1998 analysis of the costs of providing RWAA services, utilized by CMS in their original ratemaking process, still apply today, and can be adjusted for by the selection of an appropriate measure of inflation. Documentation was not found to support this assumption.
- Review of the submitted explanation of benefits finds no information to support that this methodology was used to calculate the actual reimbursement paid to the health care provider.
- 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." No documentation was presented to support that the insurance carrier employed PAFs of 118% or 109.8% in determining the amount paid, nor is there documentation contemporaneous to the medical bill processing date to support that the insurance carrier contemplated this reasoned justification in determining payment for the disputed services.
- More importantly, no documentation was found to support the respondent's proposed 125% PAF—the factor the respondent alleges to have been utilized by the insurance carrier to calculate the payment for the services in dispute.
- The respondent asserts: "Drs. Luke and Frazier then show that under previous payment policies, studies show that 100% of Medicare has not led to access issues for Medicare patients."
- However, the requestor contends: "Unlike hospitals, an air ambulance providers' participation in Medicare is not voluntary. State law and professional ethics both require air ambulance to transport all emergency patients without regard to financial status." In support of this, the requestor cites 25 Texas Administrative Code §157.36(b)(9), (12), and (28), which address potential disciplinary action by the Texas Department of State Health Services, including revocation of a license, for abandoning a patient, discriminating based on economic status, or engaging in conduct that has potential to jeopardize the health or safety of any person, or other conduct specified in those subsections. 25 Texas Administrative Code §157.12 addresses further requirements that air ambulance providers utilizing helicopters must be operated by EMS providers.

- The Division further notes that, regardless of whether an ambulance service provider is enrolled in or participates with Medicare, the Social Security Act §1834(l)(6) [42 U.S. Code 1395m(l)(6)] imposes a special "restraint on billing," requiring mandatory assignment for all ambulance services. Ambulance providers must accept the Medicare allowed charge as payment in full and may not bill or collect from the beneficiary any amount other than any unmet Part B deductible and coinsurance amounts.
- In light of state and federal regulations compelling air ambulance service providers to render services to Medicare patients regardless of reimbursement amount, the respondent has failed to support that the Medicare population is comparable to the Texas workers compensation population with regard to the question of access to services.
- The respondent 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 air ambulance services in dispute. Reimbursement is calculated as follows: review of the submitted medical bill finds that the total charge for the disputed air ambulance services is $36,877.08. The Division finds this amount to be a fair and reasonable reimbursement for the air ambulance services in dispute. Additionally, the total MAR for the professional medical services and items calculated according to the medical fee guidelines as determined above is $92.85. The total recommended reimbursement is $36,969.93. The amount previously paid by the insurance carrier is $7,200.34. Accordingly, the additional payment amount recommended is $29,769.59.

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 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 $29,769.59.

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 $29,769.59 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	October 23, 2015
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	October 23, 2015
Signature	Medical Fee Dispute Resolution Manager	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.