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
MED-TRANS CORPORATION

Respondent Name
TEXAS COTTON GINNERS TRUST

MFDR Tracking Number
M4-14-2750-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 6, 2014

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: $27,875.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was reimbursed according to Forte's fair and reasonable policy using the CMS ambulance files and increasing the allowance by 125% to be consistent with the % that TDI is using for similar CMS files. . . . Forte stands on the previous audits and recommendations"

Response Submitted by: Forté

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2013	Air Ambulance Services	$27,875.96	$27,743.83

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
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

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 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. 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.

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.
- Procedure code 93041 represents rhythm electrocardiogram, 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 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0. The practice expense (PE) RVU of 0.17 multiplied by the PE GPCI of 0.912 is 0.15504. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.16313 is multiplied by the Division conversion factor of $55.30 for a MAR of $9.02.
- 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 $0.54. 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.

3. Additionally, the health care provider rendered air ambulance services 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 W1 – "WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT." No documentation was presented to support a specific Texas fee schedule or medical fee guideline applicable to the disputed air ambulance services.

   The respondent asserts, “The bill was reimbursed according to Forte’s fair and reasonable policy using the CMS ambulance files and increasing the allowance by 125% to be consistent with the % that TDI is using for similar CMS files.”

   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.

   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 (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 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: "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 "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.

- Review of the health care provider's billed charges finds that the charges for the services in this dispute are consistent with national aggregate charge range data compiled by CMS as found in 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 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, 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. 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 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: "The bill was reimbursed according to Forte's fair and reasonable policy using the CMS ambulance files and increasing the allowance by 125% to be consistent with the % that TDI is using for similar CMS files."
   - The respondent did not submit copies of the above referenced CMS ambulance files for review.
   - The respondent did not submit documentation to support that the 125% they have chosen as their payment adjustment factor for their fair and reasonable methodology is consistent with the percentage TDI is using for similar CMS files.
   - The respondent did not explain or present documentation to support how the proposed 125% adjustment multiplied by the CMS ambulance files allowance results in a fair and reasonable reimbursement for the services provided to the injured employee.
   - 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 $40,000.30. 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 $95.50. The total recommended reimbursement is $40,095.80. The amount previously paid by the insurance carrier is $12,351.97. Accordingly, the additional payment amount recommended is $27,743.83.

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 $27,743.83.

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 $27,743.83 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	August 28, 2015
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	August 28, 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.