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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PHI AIR MEDICAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-12-3318

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 10, 2012

REQUESTOR'S POSITION SUMMARY

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

Requestor's Position Summary dated June 6, 2014: "But 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."

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"

Requestor's Position Summary dated November 14, 2014: "The affidavits submitted in connection with TMIC's November 13, 2014 letter and any summary of the affidavits in the letter, are not timely submitted, and thus, should be rejected as time-barred."

Requestor's Letter dated November 21, 2014: **"**If the Division declines to reject the affidavits submitted in connection with TMIC's November 13, 2014 letter (and any commentaries on those affidavits provided by Flahive or TMIC) as time-barred, the providers should be afforded a formal opportunity to detail the glaring inaccuracies contained in both affidavits. Should the Division accept these affidavits as additional evidence prior to rendering a decision on each of the TMIC and Flahive cases, the Division's record would not be complete without responses detailing just how incorrect the experts' assumptions, conclusions and opinions are, given the unique nature of the air ambulance industry and the manner in which the providers' Medicare rate was promulgated**."**

Amount in Dispute: $16,067.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with the Texas Medical Fee Guideline for Professional Services, Texas Mutual based its reimbursement on the Medicare Ambulance fee schedule, plus a 25 percent markup. See 28 TAC Sec. 134.203 (d) and (f)."

Response Submitted by: Texas Mutual Insurance Company

Respondent's Position Summary dated June 5, 2014: "The proper payment standard to apply in these cases in [sic] the Medicare rate pursuant to 28 Tex. Admin. Code § 134.203(b) and *(*c) . . . In the alternative, the DWC should consider whether the current Medical Fee Guideline amount of 125 percent of Medicare is the best indication of a 'fair and reasonable' reimbursement. . . . MFDR has published medical dispute decisions that state the correct amount to be paid for air ambulance services is the amount calculated under 28 Tex. Admin. Code 134.203(d), *i.e.*, 125 percent of Medicare. Medicare has published a Medicare Ambulance Fee Schedule. As a result, the air ambulance Medicare rate forms the basis for fair and reasonable reimbursement for air ambulance services in the Texas workers' compensation system and this is consistent with the statutory directives."

Response Submitted by: Texas Mutual Insurance Company

Respondent's Position Summary dated November 13, 2014: "Reimbursement at 125% of Medicare Is Fair and Reasonable and Meets the Standards of Texas Labor Code § 413.011."

Response Submitted by: Graves Dougherty Hearon & Moody

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2012	Air Ambulance Services	$16,067.20	$16,067.20

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 forth general provisions related to medical reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the medical fee guidelines for professional medical services.
4. 25 Texas Administrative Code §157.12 sets out emergency medical services provider license requirements regarding rotor-wing air ambulance operations.
5. 25 Texas Administrative Code §157.36 establishes criteria for denial and disciplinary actions for EMS personnel and applicants and voluntary surrender of a certificate or license.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. On May 6, 2014 both the requestor and respondent in this dispute were given the opportunity to supplement their original MFDR submission, position or response as applicable. The Division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the services in dispute are eligible for reimbursement.
8. The services in dispute were reduced by the respondent with the following explanation codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 635 – REIMBURSEMENT IS BASED ON THE MEDICARE AMBULANCE FEE SCHEDULE, PLUS A 25% MARKUP
   - 635 – REIMBURSEMENT IS BASED ON FAIR AND REASONABLE AS SITED IN SECTION 134.1
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 724 – NO ADDITIONAL REIMBURSEMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. Does the federal McCarran-Ferguson exempt the applicable Texas Workers' Compensation medical fee guideline from preemption by the federal Airline Deregulation Act?
2. Is 28 Texas Administrative Code §134.203(b) or (c) the applicable fee guideline for determining reimbursement of air ambulance services?
3. How is reimbursement for air ambulance services established in Texas Workers' Compensation?
4. Has the requestor justified that the payment amount sought is a fair and reasonable rate of reimbursement?
5. Has the respondent justified that the payment made is a fair and reasonable rate of reimbursement?
6. Is additional reimbursement due?

Findings

1. The requestor maintains that the Federal Aviation Act, as amended by the Airline Deregulation Act (ADA) of 1978, 49 U.S.C. §41713, preempts the authority of the Texas Labor Code to apply the Division's medical fee schedule amount. The respondent argues that the McCarran-Ferguson Act supersedes the preemption provisions of the Federal Aviation Act, as amended by the ADA. This threshold legal issue was considered by the State Office of Administrative Hearings (SOAH) in *PHI Air Medical v. Texas Mutual Insurance Company*, Docket number 454-12-7770.M4, *et al*. SOAH 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)." SOAH found that:

   > In particular, 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 all applicable rules and fee guidelines of the Texas Department of Insurance, Division of Workers' Compensation.

2. The services in dispute are air ambulance transport services billed under code A0431 and code A0436. In its original position statement, the respondent contends that "In accordance with the Texas Medical Fee Guideline for Professional Services, Texas Mutual based its reimbursement on the Medicare Ambulance fee schedule, plus a 25 percent markup. See 28 TAC Sec. 134.203 (d) and (f)." The respondent's supplemental response, dated June 5, 2014, asserts that:

   > The proper payment standard to apply in these cases in [sic] the Medicare rate pursuant to 28 Tex. Admin. Code § 134.203(b) and (c) . . . The legislature clearly intended in § 413.011 that DWC adopt the Medicare reimbursement policies with minimal modifications. The minimal modifications were specifically addressed in the rule. . . . No additions or exceptions for air ambulance services are specified in the text of Rule 134.203. The DWC did not create a specific minimal modification for air ambulance services. . . . If subsection (d) is interpreted to exclude ambulance services, then subsections (b) and (c) become important in the analysis of the proper payment for air ambulance services. The rule contains no specific provision excepting Medicare's payment policies for ambulance services. The Medicare reimbursement amount for ambulance services (assuming subsection (d) does not apply) has not been modified. Therefore, reimbursement for ambulance services would have to be the Medicare rate pursuant to subsections (b) and (c) . . .

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

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

   The respondent's contention that the payment standard to apply is the unmodified Medicare rate pursuant to §134.203(b) and (c), does not meet the requirement of Labor Code §413.011(b).

Moreover, subsections (b) and (c) of 28 Texas Administrative Code §134.203 must be read as part of the entire rule. Administrative rules are interpreted in the same manner as statutes, see *Rodriguez v. Service Lloyds Insurance Company*, 997 *South Western Reporter Second* 248, 254 (Texas 1999). Therefore, like a statute, the rule must be considered in its entirety; single subsections may not be read in isolation, see *Continental Casualty Insurance Company v. Functional Restoration Associates, et al.*, 19 *South Western Reporter Third* 393, 398 (Texas 2000). Subsection (b) contains general provisions for reimbursement of professional medical services, while subsections (c), (d) and (e) address how professional services, durable medical equipment, and clinical laboratory services respectively shall be reimbursed. Air ambulance services are not included in the categories of services discussed or listed under subsections (c), (d) and (e).

Based on the plain reading of §134.203(d), neither subparagraph (d)(1) nor (d)(2) can be construed as applicable to the air ambulance services in dispute. That is, the maximum reimbursement amounts and methods listed in subparagraphs (d)(1) and (d)(2) are not only limited to items that are billed using HCPCS Level II codes but that are also durable medical equipment, prosthetics, orthotics or supplies. Further, subparagraphs (d)(1) and (d)(2) are intended to be read together, as the "published Medicare rate" language in subparagraph (d)(2) refers *exclusively* to items listed in Medicare's DMEPOS fee schedule.

Even if subsection (d) does not apply solely to DMEPOS services, subparagraph (d)(2) would *still* not apply to air ambulance services because there *are* published Medicare rates. Thus, at most, subparagraph (d)(3) would apply and implicate fair and reasonable reimbursement pursuant to 28 Texas Administrative Code §134.1(f), which the Division finds applies for other reasons as set forth below.

The respondent has failed to support its assertion that 28 Texas Administrative Code §134.203(b) and (c) are the applicable provisions for determining reimbursement of the disputed services. The Division concludes that subsections (b) and (c) do not apply to the air ambulance services in dispute. The Division further concludes that subsection (d) is also not applicable to the disputed air ambulance services.

3. For the reasons stated, the Division cannot conclude that the *unmodified* Medicare reimbursement and payment policies referenced in §134.203(b) and (c) are applicable to transport services such as those in dispute. Review of the Division's medical fee guidelines finds no applicable fee guideline for air ambulance services. Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1, which requires that:

> (e) 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 subsection (f) of this section.

In the following analysis, the Division examines the positions of both parties and the evidence presented to date in support of, or to refute, each party's determination of a fair and reasonable payment amount, in order to establish which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the disputed services. The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

4. 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* 643, 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* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . 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), effective May 31, 2012, 37 *Texas Register* 3833, 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 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable

The Division will first review the information presented by the requestor to determine whether it has met its burden to prove that the payment amount it is seeking is a fair and reasonable rate of reimbursement for the services in this dispute. If the requestor's evidence is persuasive, then the Division will review the respondent's evidence.

Review of the submitted documentation finds that:

- The requestor asserts in its original position statement that "charges should have been considered at PHI Air Medical's billed usual and customary charge."
- The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269). While an air ambulance company is not a hospital, the above principle is of similar concern in the present case. A health care provider's usual and customary charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services. Payment of the "full 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.
- The requestor, however, has submitted additional information along with data and documentation 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), entitled *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), entitled *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 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. . . . 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 respondent argues that "The providers' own data show prices are not consistent across different providers: [another provider's] per-transport charge for its Texas program in 2013 is $10,000 higher than PHI Air Medical's." However, the respondent cites charges for an air ambulance provider other than the one involved in this dispute. Review of the health care provider's billed charges finds that the submitted charges for the services in this dispute are comparable on a base rate basis and per mile basis with the submitted Texas and national aggregate charge range data compiled by CMS as found in the requestor's Exhibit 11.
- 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 submitted documentation of the provider's revenue, expenses, and profit margins after estimated income tax for calendar years 2010 through 2013 respectively. The data supports that their margins were lower than 1% for 2011, and lower than 6% for all years, except 2012, which was lower than 12%. The requestor states that "This proves that the air ambulance charge model achieves effective cost control because it does not reflect the type of high historical profit margins that would indicate a provider's ability to raise rates to an unfair or unsustainable level."
- The requestor 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 form 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 states that "The fact that average air ambulance charges are similar throughout Texas and throughout the country is evidence that the charges are not arbitrary, and are in fact, controlled by the market . . ."

- 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.

5. 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 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's position statement dated June 5, 2014, states that "the DWC should consider whether the current Medical Fee Guideline amount of 125 percent of Medicare is the best indication of a 'fair and reasonable' reimbursement."
   - The respondent offers published Division medical dispute decisions (MFDR Tracking Numbers: M4-08-6757-01, M4-09-2551-01, and M4-08-6395-01) in support of its position that:

     > the MFDR has published medical dispute decisions that state the correct amount to be paid for air ambulance services is the amount calculated under 28 Tex. Admin. Code 134.203(d), i.e., 125 percent of Medicare. Medicare has published a Medicare Ambulance Fee Schedule. As a result, the air ambulance Medicare rate forms the basis for fair and reasonable reimbursement for air ambulance services in the Texas workers' compensation system and this is consistent with the statutory directives. The Texas workers' compensation fee guideline amount is an appropriate basis to determine 'fair and reasonable' reimbursement and this methodology generates the most reliable calculations. Therefore, the air ambulance companies should not receive reimbursement any higher than the workers' compensation fee guideline amount.

   - Review of the submitted medical fee dispute decision M4-09-2551-01 finds that it is not applicable to the services in this dispute. That decision was not decided with regard to either a consideration of a fair and reasonable reimbursement amount or application of the Division fee guidelines, but rather was based on a determination that the respondent in that dispute had already paid the additional amount sought by the requestor, and therefore a dispute no longer existed at the time of review.
   - Review of the remaining two cited Division medical fee dispute decisions, M4-08-6757 and M4-08-6395-01, decided in 2009 and 2008 respectively, finds that the submitted dispute decisions were **not** decided on the basis of a determination of a fair and reasonable reimbursement for the services in dispute, but rather were based on the incorrect assumption that the fee guideline for professional services, as found in §134.203(d)(1), was applicable to ambulance services. As stated above, 28 Texas Administrative Code §134.203(d) cannot be construed as applicable to ambulance services such as those that were the subject of these dispute decisions. That is, the maximum reimbursement amounts and methods listed in subparagraphs (d)(1) and (d)(2) are not only limited to items that are billed using HCPCS Level II codes but that are also durable medical equipment, prosthetics, orthotics or supplies. Because the services in those disputes were decided in error and were not considered under an analysis of the fair and reasonable reimbursement amount appropriate for payment of those disputed services, the decisions cannot be considered evidence of a fair and reasonable payment amount for the air ambulance services reviewed here.
   - The respondent alternatively asserts in its June 5th position statement that:

     > The DWC also has noted that fees voluntarily accepted by providers from Medicare and certain managed care payors evidence a fair and reasonable level of compensation. . . . The DWC has found Medicare rates are a relevant benchmark in implementing this standard because '[t]he Medicare fee program is also designed to achieve effective cost control, another statutory objective DWC must try to meet in its own fee guidelines.'

- The respondent argues that "According to CMS and other government sources, air ambulance provider enrollment in Medicare is voluntary. The Division should consider the provider's voluntary acceptance of Medicare payments in determining a fair and reasonable reimbursement."
- Review of the respondent's information finds no documentation to support that the requestor has voluntarily accepted fees from Medicare or certain managed care payors.
- The Division further notes that regardless of whether enrollment in Medicare is voluntary, the acceptance of payments from Medicare for providers who are not enrolled is not voluntary. The Social Security Act §1834(l)(6) [42 U.S. Code 1395m(l)(6)], imposes a "restraint on billing" and requires mandatory assignment for all ambulance services. Ambulance providers and suppliers must accept the Medicare allowed charge as payment in full and not bill or collect from the beneficiary any amount other than any unmet Part B deductible and the Part B coinsurance amounts.
- While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), as stated above, Texas Labor Code §413.011(b) requires that:

  > In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d) . . . This section does not adopt the Medicare fee schedule, 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.

- The respondent's proposed alternative methodology (regarding the use of unadjusted Medicare rates) relies solely on conversion factors and payment adjustment factors developed by CMS, and has not taken into account economic indicators in health care or the requirements of §413.011(d). Therefore, the respondent fails to support that this alternative methodology results in a "fair and reasonable" amount of reimbursement.
- Moreover, the respondent has not controverted the requestor's position that "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. Because: (1) acceptance of Medicare rates for Medicare-covered patients is required, (2) Medicare rates are substantially lower than the standard reimbursement rate received by the requestor for almost all other customers, and (3) the requestor maintains relatively low profit margins for all customers, the Division cannot find that Medicare rates satisfy the "fair and reasonable" fee criteria in the absence of documentation to support that the proposed reimbursement meets the statutory and rule requirements.
- Furthermore, the unmodified Medicare reimbursement methodology was not the methodology used to calculate the reimbursement amount paid by the insurance carrier. As stated above, §133.307(d)(2)(E)(v) requires the respondent to discuss, demonstrate, and justify that the amount the respondent paid is a fair and reasonable reimbursement. 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 Division therefore concludes that alternate reimbursement amounts and methodologies put forward by the respondent that are not the basis of the payment made by the insurance carrier during the medical billing process cannot be considered as part of the carrier's justification, pursuant to §133.307(d)(2)(E)(v), that the amount it paid was a "fair and reasonable" reimbursement. Accordingly, the Division here reviews the respondent's documentation to support and justify the amount the insurance carrier paid for the services in dispute.
- The respondent asserts in its November 13, 2014 supplemental response that "Reimbursement at 125% of Medicare Is Fair and Reasonable and Meets the Standards of Texas Labor Code § 413.011."
- No documentation was found to support the Medicare fee calculation for the disputed services.
- No documentation was found to support that the insurance carrier's payment was consistent with its proposed methodology.
- The respondent further asserts that "Medicare-based reimbursement is especially appropriate for use with respect to air ambulance services because CMS developed its air ambulance payment through a *negotiated* rulemaking in which the air ambulance industry voluntarily participated."

- The respondent presents expert testimony from Ronald T. Luke, who states in paragraph 7.d of his affidavit that “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 that:

  > 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%.

- Review of the submitted explanation of benefits finds that this methodology was not used to calculate the actual reimbursement paid to the requestor. As stated above, Rule 134.1(g) requires the insurance carrier to consistently apply fair and reasonable reimbursement amounts and maintain documentation of the methodologies used to establish those amounts during the medical billing process. The insurance carrier did not employ PAFs of 118% or 109.8% in determining the amount paid, nor is there documentation contemporary to the medical bill processing date to support that the requestor contemplated and documented this reasoned justification.
- More importantly, no documentation was found to support the insurance carrier’s 125% PAF—the factor utilized by the insurance carrier to calculate the payment for the services in this dispute.
- Additionally, the 118.8% and 109.8% PAFs assume that the 1998 analysis of the costs of providing RWAA services, utilized by CMS in their 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 information finds that the respondent has failed to support the insurance carrier's methodology(ies) establishing that the amount paid to the requestor was a fair and reasonable amount in accordance with §134.1(g).
- The Division finds that the insurance carrier has failed to support the proposed payment adjustment factor of 125% that it employed in calculating the reimbursement it paid. 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%.
- The respondent did not support that the amount paid represents a fair and reasonable reimbursement for the services in dispute.
- The respondent did not support that the amount paid satisfies the requirements of 28 Texas Administrative Code §134.1.

The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has failed to demonstrate and justify 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).

6. 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 services in this dispute. Reimbursement is calculated as follows: review of the submitted medical bill finds that the total charge for the disputed services is $20,882.00. 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 $4,814.80. Accordingly, the additional payment amount recommended is $16,067.20.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, 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 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 has been found to be persuasive. In turn, the evidence provided by the respondent was not found to be 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 $16,067.20.

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 $16,067.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signatures

	Grayson Richardson	January 22, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *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 MDR 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.