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
RICHARDSON FIRE DEPT AMBULANCE

Respondent Name
TRAVELERS CASUALTY & SURETY COMPANY

MFDR Tracking Number
M4-12-3356-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 16, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are seeking our bill to be processed and paid at 100% of the billed charge as there is no workers comp fee schedule rate for 911 ambulance services. We billed Liberty Mutual [sic] the same rates we bill all insurance companies. This is the usual and customary rate we bill all insurance companies in our service region and should therefore be paid in full, as billed."

Amount in Dispute: $229.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Ambulance services are billed under HCPCS Level II Code A, for example A0429 and A0425 for the services in dispute here. Consequently, Texas has clearly adopted a workers' compensation fee schedule for ambulance services. . . . As such, the Carrier properly reimbursed the Provider under the Texas workers' compensation fee schedule set forth in rule 134.203, and the Provider ins not entitled to full billed charges."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2011	Ambulance Services	$229.54	$0.00

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 fee guidelines for professional medical services provided on or after March 1, 2008.
4. Former 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services provided on or after September 1, 2002.

5. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
6. The Division takes notice that the requestor has listed the date of service for procedure codes A0429 and A0425 as September 19, 2011 on the requestor's *Table of Disputed Services*. Review of the submitted documentation finds that the date of service for all services in this dispute was September 15, 2011. The Division concludes that the date listed on the requestor's DWC060 form is the result of a typographical error. The Division will therefore deem the disputed date of service to be September 15, 2011 for the purpose of this review.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - TXS2 – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. AMBULANCE SERVICES ARE REIMBURSED AT 125% ABOVE THE CMS FEE SCHEDULE AMOUNT FOR THE TYPE OF SERVICE AND LOCALITY.
   - S2TX – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. AMBULANCE MILEAGE SERVICES ARE REIMBURSED AT 125% ABOVE THE CMS FEE SCHEDULE AMOUNT FOR THE TYPE OF SERVICE, LOCALITY AND NUMBER OF MILES TRAVELED.
   - PAY – W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. IF REDUCTION, THEN PROCESSED ACCORDING TO THE TEXAS FEE GUIDELINES.

Issues

1. What is the applicable rule for determining reimbursement of ambulance services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced payment for the disputed services with reason codes TXS2 – "W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. AMBULANCE SERVICES ARE REIMBURSED AT 125% ABOVE THE CMS FEE SCHEDULE AMOUNT FOR THE TYPE OF SERVICE AND LOCALITY."; S2TX – "W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. AMBULANCE MILEAGE SERVICES ARE REIMBURSED AT 125% ABOVE THE CMS FEE SCHEDULE AMOUNT FOR THE TYPE OF SERVICE, LOCALITY AND NUMBER OF MILES TRAVELED."; and PAY – "W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. IF REDUCTION, THEN PROCESSED ACCORDING TO THE TEXAS FEE GUIDELINES.COMPENSATION STATE FEE SCHEDULE ADJUSTMENT." No documentation was found to support a specific Texas fee schedule relevant to the disputed services. The respondent's position statement asserts that "Ambulance services are billed under HCPCS Level II Code A, for example A0429 and A0425 for the services in dispute here. Consequently, Texas has clearly adopted a workers' compensation fee schedule for ambulance services."

   Per 28 Texas Administrative Code §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% under (d)(1) must be: (1) a HCPCS Level II code A, E, J, K, or L; (2) durable medical equipment, a prosthetic, an orthotic or a supply; and (3) included in Medicare's DMEPOS fee schedule. All these requirements must be met for a service to be payable at 125% of the Medicare (DMEPOS) rate. 28 Texas Administrative Code §134.203(d)(1) 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 preambles to current 28 Texas Administrative Code §134.203, and the equivalent sections of former 28 Texas Administrative Code §134.202 further support that the 125% payment adjustment factor was not intended to apply to transport services or the Medicare air ambulance fee schedule. These resources explain, in pertinent part, that:

   > 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)

and that:

> 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 sub-paragraphs were durable medical equipment, prosthetics, orthotics and supplies found in Medicare's DMEPOS fee schedule.

Review of the submitted documentation finds that the services in dispute are A0431 — Ambulance Services, conventional air services, transport; and A0436 — Rotary wing air mileage, per statue mile; both classified as Transport Services. The Division concludes that the services in dispute are not durable medical equipment, prosthetics, orthotics or supplies, and are not found in the Medicare DMEPOS fee schedule. The respondent's payment reduction reason code of W1 – "WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT" is not supported.

Based on the plain reading of §134.203(d), and clarifications found in the aforementioned preambles, neither subparagraph (1) nor subparagraph (2) of (d) can be construed as applicable to the air ambulance services in dispute. The maximum reimbursement amounts and methods stated in (d)(1) and (d)(2) are limited to services that are billed under HCPCS Level II codes and that are also durable medical equipment, a prosthetic, an orthotic or a supply. Moreover, (d)(1) and (d)(2) are intended to be read together, as the "published Medicare rate" language in (d)(2) refers exclusively to items listed in Medicare's DMEPOS fee schedule. Even if (d) does not apply solely to DMEPOS services, (d)(2) is not applicable to air ambulance services because there is a published Medicare rate for air ambulance services. Thus, at most, (d)(3) would apply and implicate fair and reasonable reimbursement pursuant to rule 134.1(f).

The general medical reimbursement provisions at 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).

Review of the Division's medical fee guidelines finds no applicable fee guideline for air ambulance services. Neither party alleges that there is an applicable negotiated contract. In the absence of an applicable fee guideline or a negotiated contract, §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 therefore concludes that 28 Texas Administrative Code §134.1(f) is the applicable rule for determining reimbursement of the air ambulance services in dispute.

2. The services in dispute are ambulance transportation services for which the Division has not established a medical fee guideline. Reimbursement is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f).

   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 "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." The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

Review of the submitted documentation finds that:

- The requestor's position statement asserts that "We billed Liberty Mutual [sic] the same rates we bill all insurance companies. This is the usual and customary rate we bill all insurance companies in our service region and should therefore be paid in full, as billed."
- 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 did not provide other data or documentation to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

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.

For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	April 24, 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.