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
PHI AIR MEDICAL

Respondent Name
TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

MFDR Tracking Number
M4-12-3665

Carrier's Austin Representative
Box Number 05

MFDR Date Received
August 23, 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"

Amount in Dispute: $24,946.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reviewed the billing and reimbursed the Provider at the Medicare rate relevant to these services. . . . Under the Deregulation Act cited above, only the federal government may set rates for air ambulance carriers. . . . the FAA has delegated the responsibility for setting the reimbursement rates for air ambulance services to the Centers for Medicare/Medicaid Services. . . . reimbursement should be calculated under the federal reimbursement regulations at the *lesser of* billed charges or the Medicare fee schedule rate for the air ambulance services rendered."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2012	Air Ambulance Services	$24,946.60	$24,946.60

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. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. 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.
6. The services in dispute were reduced by the respondent with the following explanation codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - T266 – AIR AMBULANCE CARRIER SERVICES ARE REIMBURSED BASED ON THE MEDICARE FEE SCHEDULE WHICH IS THE LESSER OF BILLED CHARGES OR THE MEDICARE FEE SCHEDULE.
   - TXS2 – AMBULANCE SERVICES ARE REIMBURSED AT 125% ABOVE THE CM FEE SCHEDULE AMOUNT FOR THE TYPE OF SERVICE AND LOCALITY.
   - T263 – AIR AMBULANCE CARRIER SERVICES ARE REIMBURSED BASED ON THE MEDICARE FEE SCHEDULE WHICH IS THE LESSER OF BILLED CHARGES OR THE MEDICARE FEE SCHEDULE.
   - 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.

Issues

1. Does the Federal Aviation Act preempt the authority of the Texas Labor Code to regulate air ambulance services?
2. Are the disputed services subject to reimbursement under the Medicare fee schedule?
3. Is there a fee guideline for air ambulance services?
4. How is reimbursement for air ambulance services established in Texas Workers' Compensation?
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*, Docket number 454-12-7770.M4, *et al*., 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)." 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. The respondent contends that:

> The Federal Aviation Administration regulates air ambulance carriers, such as the Provider herein. Under the Deregulation Act cited above, only the federal government may set rates for air ambulance carriers. Due to the medical nature of the services rendered and the federal responsibility for reimbursement of those services, the FAA has delegated the responsibility for setting the reimbursement rates for air ambulance services to the Centers for Medicare/Medicaid Services. The CMS regulations state that reimbursement for air ambulance services are the lesser of the air ambulance billed charges or the Medicare fee schedule which CMS sets pursuant to the delegation of authority from the FAA.

Review of the submitted information finds no documentation to support that the FAA has delegated the responsibility for setting the reimbursement rates for air ambulance services to the Centers for Medicare and Medicaid Services. No documentation was found to support any delegation of authority from the FAA.

As stated above, the Division has found 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; therefore, this dispute is decided pursuant to the provisions of the Texas Labor Code and all applicable Division rules and fee guidelines.

Moreover, 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, 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 does not meet the requirements of Labor Code §413.011(b).

3. The respondent reduced or denied payment for disputed services with reason codes W1 – "WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT."; TXS2 – "AMBULANCE SERVICES ARE REIMBURSED AT 125% ABOVE THE CM 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." No documentation was found to support a specific Texas fee schedule relevant to the disputed 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.

Based on the plain reading of §134.203(d) , and clarifications found in the above mentioned preambles, 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 §134.203(f) and §134.1. The Division concludes that the reimbursement provisions of §134.203 are not applicable to the disputed air ambulance services.

4. Review of Division rules finds no applicable medical fee guideline for air ambulance services. No documentation was found to support a negotiated contract or that the services were provided through a workers' compensation health care network. Payment 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).

   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.

5. 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 "reimbursement should have been made subject to PHI Air Medical's 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 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.

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 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:

- It is unclear what methodology(ies) the insurance carrier used to calculate reimbursement for the disputed services. The respondent's position statement asserts that "The Carrier reviewed the billing and reimbursed the Provider at the Medicare rate relevant to these services." However, the submitted explanations of benefits state that "AMBULANCE SERVICES ARE REIMBURSED AT 125% ABOVE THE CM FEE SCHEDULE AMOUNT FOR THE TYPE OF SERVICE AND LOCALITY."
- No documentation was found to support the insurance carrier's calculation of the Medicare fee schedule amount.
- As stated above, there is no specific fee guideline for air ambulance services; therefore, the applicable rule for determining payment for the disputed services is §134.1(f) regarding fair and reasonable reimbursement.
- As further stated above, the Division may not consider the unmodified Medicare rate as an appropriate fee, as the Legislature has 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, 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."
- 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 insurance carrier failed to support the proposed payment adjustment factor of "125% ABOVE THE CM FEE SCHEDULE AMOUNT." 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 specific payment adjustment factor of 125% above the CM fee schedule amount.
- 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).

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 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 $32,377.00. 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 $7,430.40. Accordingly, the additional payment amount recommended is $24,946.60.

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 $24,946.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $24,946.60 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signatures

	Grayson Richardson	February 13, 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.