

DOCKET NO. 454-15-0681.M4, et al.

IN RE: § **BEFORE THE STATE OFFICE**
§
REIMBURSEMENT OF AIR §
AMBULANCE SERVICES PROVIDED § **OF**
BY PHI AIR MEDICAL §
§
§
§ **ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

This case involves challenges by numerous insurance companies (Carriers) to Medical Fee Dispute Resolution (MFDR) decisions by the Texas Department of Insurance, Division of Workers' Compensation (DWC) ordering additional reimbursement for air ambulance services provided by PHI Air Medical (PHI). After considering the evidence and arguments presented, the Administrative Law Judge (ALJ) finds that the proper reimbursement for the air ambulance services in dispute is 149% of the Medicare reimbursement amount. This rate reflects the per-transport average amount of revenue that allows PHI to recover its costs and earn a reasonable profit. This amount meets the statutory standards, reflects the cost of service (plus profit) for the services at issue, and allows for a reimbursement that neither unfairly subsidizes other patient populations nor requires subsidization by other populations. Consistent with this rate, the ALJ finds that PHI is entitled to additional reimbursement in the amounts reflected on Attachment 1 to this Decision and Order.

I. SUMMARY OF THE CASE

This case involves a dispute between PHI and Carriers over the proper reimbursement for medical air ambulance services provided to injured workers (claimants) for compensable injuries under Texas workers' compensation insurance. PHI has no direct contract with Carriers. Rather, the claimants' employers contracted with Carriers to provide insurance coverage for the claimants, who are the beneficiaries of such contracts.

There are essentially two primary issues in this case: (1) does the federal Airline Deregulation Act (ADA)¹ preempt state law that establishes the proper methodology for reimbursement of medical services under workers' compensation insurance? And (2) if state law is not preempted, what is the proper reimbursement under the Texas Workers' Compensation Act, Texas Labor Code § 401.001, *et seq.* (TWCA) for the air ambulance services at issue?

¹ Specifically, 49 U.S.C. § 41713(b).

The ALJ previously determined—and continues to stand by that determination—that state workers’ compensation laws establishing proper reimbursement rates for the services at issue are not preempted by the ADA. Thus, the ALJ looks to state workers’ compensation statutes and rules to determine the proper reimbursement for the services at issue. After considering the evidence and the applicable statutory factors for determining a reimbursement rate, the ALJ concludes that 149% of Medicare reimbursement is the proper amount that satisfies the statutory criteria.

PHI’s request to be reimbursed its billed charges is untenable under the TWCA because its billed charges do not satisfy the statutory reimbursement criteria and would result in workers’ compensation patients unfairly subsidizing the vast majority of PHI’s other patients. This is not acceptable under the requirements of the TWCA. Similarly, Carriers’ request to pay only 125% of Medicare is inadequate, as it does not satisfy the statutory factors and would result in workers’ compensation claimants having to be subsidized by other higher-paying patients. This also is inconsistent with the TWCA. In contrast, a reimbursement rate of 149% of Medicare results in PHI being reimbursed an amount that is as close to “subsidization-neutral” as possible, resulting in a reimbursement reflecting the actual average costs and reasonable profit of PHI in providing services to workers’ compensation claimants. This amount satisfies the statutory criteria and avoids cross-subsidization in either direction with workers’ compensation claimants.

II. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

This matter involves 33 cases joined for hearing. Each case has its own procedural history, which is not restated here. All share a common background: they each involve the provision of air ambulance services by PHI to injured workers covered by insurance provided under the TWCA. In each case, Carriers reimbursed less than PHI’s billed charges and PHI requested MFDR with DWC, seeking to be reimbursed its full billed charges. DWC initially dismissed the cases, finding that the ADA preempted application of the TWCA to the disputes. Carriers appealed to the State Office of Administrative Hearings (SOAH), and the matter was assigned to ALJ Craig R. Bennett. After taking arguments from the parties, the ALJ issued an order remanding the cases back to DWC for MFDR, finding that the ADA did not preempt application of the TWCA to the fee disputes.

Subsequently, DWC issued a decision in each of the 33 cases requiring Carriers to reimburse PHI its billed charges for the air ambulance services provided. Carriers then timely requested a hearing before SOAH to contest each of the MFDR decisions, and the 33 cases involved in this matter were joined together for hearing.²

² Many similar air ambulance cases have subsequently been referred to SOAH, but those cases have been abated under a separate lead docket number, SOAH Docket No. 454-15-1877.M4, pending issuance of the decision in this case.

An evidentiary hearing was convened before ALJ Craig R. Bennett on April 22-24, 2015, at SOAH's facilities in Austin, Texas. PHI appeared and was represented by attorneys Andres Medrano and Leslie Robnett. Carriers appeared and were represented by attorneys James Loughlin and Matthew Baumgartner. The record was formally closed on August 27, 2015, after the parties submitted a spreadsheet containing details on the fees in dispute. Except as to the application of the ADA, no parties have raised jurisdictional or notice challenges, and those matters are addressed in the findings of fact and conclusions of law without further discussion here.

III. THRESHOLD LEGAL ISSUE

As noted above, a threshold legal issue exists—namely, whether the TWCA is preempted by the ADA.³ Previously, the ALJ found that the ADA did not preempt the TWCA and the rules implementing it because such laws were clearly directed toward regulating the business of insurance. A separate federal law, the McCarran-Ferguson Act,⁴ explicitly reserves the regulation of insurance to the states and provides that any federal law that infringes upon that regulation is preempted by state insurance laws, unless the federal law specifically relates to the business of insurance.

The ALJ found previously that the workers' compensation system adopted in Texas is directly related to the business of insurance, as it establishes a comprehensive framework for providing and administering insurance coverage for injured workers. The payment resolution processes, as well as the allowable benefit amounts and reimbursement factors set out by statute or DWC, are integrally related to the business of insurance. Thus, the ALJ concluded that the ADA—which does not regulate insurance—does not preempt the application of the TWCA nor the ability of DWC to establish reimbursement rates, timelines for reimbursement, rules determining the extent of coverage, and numerous other requirements related to the administration of the workers' compensation insurance program, even when such regulations are applied to air ambulance providers. The insurance system itself, as established by the legislature, is designed for effective cost containment, and reimbursement rates are a key component of the system. The TWCA's reimbursement requirements, as well as medical fee guidelines and other payment rules, are part of the business of insurance and, pursuant to the McCarran-Ferguson Act, the ADA does not preempt or invalidate them, even as applied to air ambulance services.

PHI filed a motion for summary disposition in this case, asking the ALJ to reconsider his prior ruling on this threshold jurisdictional question. In its motion, PHI asserts that the Texas

³ PHI might argue that this is not the proper framing of the issue, but rather the issue is simply whether the TWCA's reimbursement provisions are preempted by the ADA, precluding reimbursement at an amount less than an air carrier's billed charges. However, the ALJ finds it appropriate to address the issue in the broader sense, because the TWCA's reimbursement provisions are a non-severable part of a broad regulatory scheme that affects both the price and service of an air carrier; thus, the overarching issue is whether the TWCA is preempted by the ADA.

⁴ 15 U.S.C. § 1011-1015.

workers' compensation laws in issue regulate the "business of insurance companies," rather than the "business of insurance." Because of this, PHI asserts that the McCarran-Ferguson Act does not provide for reverse preemption of the ADA by state law. The ALJ disagrees.

The TWCA provides a comprehensive scheme of insurance for injured workers in Texas whose employers participate. It addresses virtually every aspect of the application of workers' compensation insurance in the state, including the assurance of medical care for claimants, lost income benefits for claimants, and dispute resolution processes for all participating parties (including medical fee disputes between carriers and providers of goods or services to injured workers covered by such insurance), among other things. The TWCA does not regulate the "business of insurance companies"—rather, it directly regulates the business of insurance, specifically workers' compensation insurance. It would be hard to find a more comprehensive regulatory scheme for the business of insurance than the TWCA. PHI's efforts to characterize it otherwise are entirely misplaced.

Accordingly, the ALJ declines to reverse his prior ruling, but instead continues to find that the McCarran-Ferguson Act applies to this case and results in the TWCA preempting the application of the ADA, particularly in regard to the issue of determining the proper reimbursement owed by Carriers to PHI for the air ambulance services provided to the workers' compensation claimants at issue. Therefore, the ALJ finds that PHI is entitled to receive reimbursement only within the limits allowed by the TWCA.⁵ So, the ALJ now turns to that act's reimbursement provisions.

IV. RECOVERY UNDER THE TEXAS WORKERS' COMPENSATION ACT

A. Applicable Law

The TWCA requires DWC to adopt health care reimbursement policies and guidelines for reimbursement of services provided to injured claimants under insurance provided pursuant to the TWCA. DWC has adopted numerous medical fee guidelines. If a specific medical fee guideline provides for a reimbursement rate for a service, then that rate is ordinarily what is permitted. However, if a medical fee guideline has not been adopted for a particular service, then the insurance carrier is to reimburse the provider a fair and reasonable amount that is consistent with the requirements of Texas Labor Code § 413.011.

Texas Labor Code § 413.011 identifies a number of requirements for determining an appropriate reimbursement amount for services provided under the TWCA. Specifically, that statute lists the following requirements:

⁵ In its motion for summary disposition, PHI also requested that, if the ALJ found that the ADA did not preempt the TWCA, then the ALJ also issue a ruling that PHI could balance bill the workers' compensation claimants who received the services. The ALJ finds that this issue goes beyond the scope of the ALJ's authority in this case and is more properly within the jurisdiction of the judiciary. Accordingly, the ALJ declines to grant the relief requested and does not spend time in this Decision and Order addressing it in more detail.

The reimbursement amount is not to be simply a conversion factor or other payment adjustment factor based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services (CMS); [Texas Labor Code § 413.011(b)]

The reimbursement amount must be fair and reasonable; [Texas Labor Code § 413.011(d)]

The reimbursement amount must be designed to ensure the quality of medical care; [Texas Labor Code § 413.011(d)]

The reimbursement amount must be designed to achieve effective medical cost control; [Texas Labor Code § 413.011(d)]

The reimbursement amount 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; [Texas Labor Code § 413.011(d)].

The reimbursement amount must take into account the increased security of payment afforded by the TWCA. [Texas Labor Code § 413.011(d)]

So, in determining the proper reimbursement to PHI for the air ambulance services at issue, the ALJ must take into account these statutory factors.⁶

Because PHI prevailed in the MFDR decisions issued by DWC, Carriers have the burden of proof in this case. This is a *de novo* proceeding in which the standard of proof is simply “preponderance of the evidence.”⁷ Thus, it is Carriers’ burden to establish, by a preponderance of the evidence, the appropriate reimbursement amount for the air ambulance services in dispute. If the preponderant evidence does not establish the appropriate reimbursement, then PHI would be entitled to receive its billed charges, because that is the amount ordered in the MFDR decisions.

⁶ DWC Rule 134.1 also requires that a fair and reasonable reimbursement rate ensure that similar procedures provided in similar circumstances receive similar reimbursement, and be based on nationally recognized published studies, published DWC medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available. 28 Tex. Admin. Code § 134.1(f). These elements were not significant in the determination of a rate, and the ALJ does not analyze them in detail. Rather, the ALJ briefly discusses them in a footnote at the conclusion of this Decision and Order.

⁷ See Decision and Order, 454-12-5501 (Oct. 31, 2012) at 3-5, for a detailed discussion of the burden of proof.

B. Carriers' Arguments⁸

In their closing arguments, Carriers assert that 125% of Medicare reimbursement is the proper reimbursement amount for the air ambulance services at issue. Carriers first argue that this is the amount allowed by DWC rule at 28 Texas Administrative Code § 134.203 (referred to hereafter simply as "Rule 134.203"). That rule provides, in part:

(d) The MAR [maximum allowable reimbursement] 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.

Carriers assert that, although there is no listing for ambulance services (whether ground or air) in the Medicare DMEPOS, there is a Medicare Ambulance Fee Schedule that qualifies as a "published Medicare rate" within the meaning of Rule 134.203(d). Specifically, the codes for air ambulance services are A0431 [ambulance service, conventional air services, transport, one way (rotary wing)] and A0436 [rotary wing air mileage, per statute mile]. These are HCPCS Level II A codes, and Medicare sets payments for these codes in its Ambulance Fee Schedule published on CMS's website. Thus, according to Carriers, reimbursement of air ambulance services should fall under Rule 134.203—presumably subsection (d)(1), although Carriers' arguments are not entirely clear on this—resulting in reimbursement at 125 percent of the Medicare fee for the services.

Carriers recognize that the literal reading of this rule does not encompass air ambulance services because they are not listed in the Medicare DMEPOS, but argue that it would be an absurd result to not include them within the meaning of the rule when there is a Medicare rate established for them. Carriers argue that none of the provisions of Rule 134.203 would apply to air ambulance services if read literally. They point out that because Medicare has published a rate for air ambulance services, then Rule 134.203(d)(2) could not apply. Thus, the default is

⁸ Carriers and PHI have filed considerable briefing in this case, addressing many different arguments—numerous of which relate simply to the reliability of evidence or other tangential issues the ALJ finds unnecessary to reach. Because this is a final decision and not a proposal for decision, the ALJ does not restate the parties' arguments in detail. Rather, the ALJ simply provides a short summary of the parties' more significant positions.

Subsection (d)(3) of Rule 134.203, which then applies Subsection (f). However, Carriers note that Subsection (f) states that it applies “[f]or products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid . . . , or the Division.” Since Medicare has assigned a value for air ambulance services, albeit not in the DMEPOS, Carriers argue that Subsection (f) could not apply either.

Because of these alleged conflicts in Rule 134.203, Carriers argue that the most logical reading is to treat air ambulance services as being encompassed within the essence of Rule 134.203 [again, presumably subsection (d)(1)], as if the rate were listed on the Medicare DMEPOS even though it is not. Thus, Carriers argue that air ambulance services ought to be reimbursed at 125% of Medicare pursuant to Rule 134.203.

Carriers contend that even if Rule 134.203(d)(1) does not apply, 125% of Medicare is the fair and reasonable reimbursement amount under Rule 134.203(f). As noted above, if Rule 134.203(d)(1) and (2) do not apply, then Subsection (d)(3) applies and ultimately leads to the application of Rule 134.1, which is DWC’s catch-all provision. Under that provision, the reimbursement must simply be fair and reasonable, which means that the reimbursement (1) is consistent with the requirements of Texas Labor Code § 413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based upon nationally recognized published studies, published DWC medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.⁹ Carriers argue that 125% of Medicare meets these criteria.¹⁰

To demonstrate that 125% of Medicare is fair and reasonable, Carriers presented the testimony of Dr. Ron Luke, an expert economist.¹¹ Dr. Luke testified that the Medicare reimbursement amount for air ambulance services has not kept pace with inflation and does not reflect the cost of new equipment in the industry. So, he made adjustments to account for these factors. Based upon his adjustments, he determined that the resulting fair and reasonable reimbursement amounts for the 2010-2013 time period were between 115% and 120% of Medicare for air ambulance transport charges, and between 107% and 111% of Medicare for mileage charges.¹² Thus, according to him, 125% of Medicare was more than fair and reasonable.

⁹ 28 Tex. Admin. Code § 134.1(f).

¹⁰ Carriers also spend considerable attention to briefing past workers’ compensation fee guidelines and decisions to demonstrate how 125% of Medicare is consistent with past decisions and rules. The ALJ finds it unpersuasive to attempt to determine a current reimbursement amount based upon past rules or decisions, which have been a source of near constant dispute and change over the last 15 years. For example, the DWC decisions underlying this case require reimbursement at PHI’s billed charges, but past DWC decisions have required reimbursement at 125% of Medicare. Given such conflicts, the ALJ analyzes this case under the existing legal standards alone.

¹¹ Dr. Luke relied on the data supplied by Jeff Frazier, another witness offered by Carriers. Mr. Frazier testified to air ambulance costs structure and expenses. The ALJ finds it unnecessary to discuss Mr. Frazier’s testimony in detail, as he primarily just supplied the data relied upon by Mr. Luke. Because the ALJ disagrees with Dr. Luke’s opinions, but not necessarily his data, it is unnecessary to determine whether the data he relied upon was reliable.

¹² See Carriers’ Exs. 46 and 50; Tr. Vol. 1 at 303.

In reaching his conclusion, Dr. Luke considered the statutory factors set out in the TWCA. Dr. Luke noted that the availability of air ambulance services has grown significantly in the last decade, including within Texas, even with the existing Medicare reimbursement rates. According to Dr. Luke, this showed that the Medicare rate was sufficient to ensure access to care. Dr. Luke further analyzed the data and found that the Medicare rate would still allow for a reasonable profit if a provider operated at least 30 flights per aircraft, per month, at each of its bases. Dr. Luke noted that 125% of Medicare covers all of PHI's marginal costs and provides for an additional margin of contribution toward PHI's fixed costs and profit. Thus, according to Dr. Luke, PHI had an incentive to accept patients at the rate of 125% of Medicare because it was economically better off than if it did not accept them.¹³ Because of this, Dr. Luke testified that 125% of Medicare still ensured access to care.

Dr. Luke also testified that 125% of Medicare properly addresses the other factors in the TWCA. Namely, 125% of Medicare takes into account an equivalent population (Medicare population), allows for effective cost control (a lower payment is more "cost-controlling" by nature), and provides for the increased security of payment afforded by the TWCA. In fact, Dr. Luke noted that 125% of Medicare is actually equal to or higher than the amount paid by or on behalf of 72% of PHI's patients.¹⁴

Finally, Carriers dispute that PHI's proposed reimbursement of billed charges is consistent with the statutory standards. Carriers note that reimbursement at billed charges is essentially the highest reimbursement amount that would exist for any of PHI's patient base. As such, it makes no provision for the security of payment under the TWCA, it does not achieve any cost control, and it results in a much higher reimbursement than that paid by or on behalf of equivalent populations (such as the 72% of PHI's patients that pay at or below 125% of Medicare). Given these concerns, Carrier contends that Provider's billed charges clearly do not satisfy the statutory criteria.

C. PHI's Arguments

PHI contends that Carriers' methodology is fatally flawed and asserts it should receive its full billed charges.

PHI argues that Carriers' proposed reimbursement of 125% of Medicare is simply "a conversion factor or other payment adjustment factor" based solely on Medicare rates, which is explicitly prohibited by Texas Labor Code § 413.011(b). Accordingly, PHI argues that the rate proposed by Carriers fails for this reason alone.

¹³ Tr. Vol. 1 at 217-18.

¹⁴ Tr. Vol. 2 at 311; Carriers' Ex. 189 at 35.

PHI also argues that Carriers' methodology is flawed because it fails to take into account PHI's payer mix. Specifically, PHI receives a wide range of reimbursement amounts. For a relatively high percentage of patients, it receives nothing and must turn the accounts over to collections; for other patients, it receives only Medicare reimbursement rates; while for even other patients it may receive full billed charges. Overall, this payer mix allowed PHI to make an after-tax profit of approximately 5% for the period between 2010 and 2013. PHI contends that a reimbursement rate of 125% of Medicare for its services would result in losses of approximately \$10 million, if that were the reimbursement amount paid by each patient covered by insurance. This is unsustainable and would not ensure the quality of medical care. PHI asserts that its business model would not allow it to stay in business if 125% of Medicare is the amount it is allowed to collect from its non-governmental insurance patients.

Because a rate of 125% of Medicare would reflect a loss on each transport, PHI argues that rate would not ensure access to quality care. Instead, for it to continue to maintain its limited profitability, PHI argues it should be allowed to recover its full billed charges from Carriers and other private insurers.¹⁵

D. ALJ's Analysis

After getting past the threshold legal issue addressed in Section III of this decision, the sole remaining issue is deciding the proper reimbursement amount for the services in dispute. In this regard, there are two key issues presented in this case: (1) does Rule 134.203 set the reimbursement amount at 125% of Medicare; if not, then (2) what is the fair and reasonable reimbursement for the services under the applicable rules and statutes. Each of these issues is discussed below.

1. Does Rule 134.203 Set Reimbursement at 125% of Medicare?

The ALJ concludes that Rule 134.203 does not establish the reimbursement amount at 125% of Medicare. In the initial MFDR decisions in the 33 cases pending in this docket, DWC determined uniformly that Rule 134.203 did not set the reimbursement at 125% of Medicare. DWC reached this decision because air ambulance services do not literally fall within the plain language of the rule. The ALJ agrees with the bulk of the reasoning set out in the DWC decisions, except as noted below.

DWC found that Rule 134.203 did not apply to air ambulance services. The ALJ does not necessarily agree with that, but finds it unnecessary to definitively decide the issue because even if Rule 134.203 applies, it leads to the same outcome. Assuming *arguendo* that Rule

¹⁵ PHI addresses many other matters in its briefing—mostly attacks on Carriers' reasoning and data, which the ALJ does not discuss. However, PHI did not demonstrate how its billed charges actually satisfy the statutory standards.

134.203 applies, then the question is where air ambulance services fit in that rule.¹⁶ Subsection (d) of Rule 134.203 states that “[t]he MAR for [HCPCS] Level II codes A, E, J, K, and L shall be determined as follows . . .” Because air ambulance services are billed under HCPCS Level II code A, subsection (d) appears to apply.

Under subsection (d), there are three potential grounds for reimbursement: (1) 125% of the fee listed for the code in the DMEPOS fee schedule; (2) if the code has no published Medicare rate, 125% of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither (1) nor (2) apply, then as calculated according to subsection (f) of Rule 134.203. Subsection (f) simply refers back to the general fair and reasonable reimbursement factors of Rule 134.1. There is no fee for air ambulance services listed in the DMEPOS or Texas Medicaid fee schedule, so neither subsections (d)(1) or (d)(2) apply, leaving only (d)(3) to apply, which then refers to subsection (f). Because subsection (f) takes us back to Rule 134.1, which applies the fair and reasonable standards of TWCA 413.011, this is essentially the same result as if Rule 134.203 did not apply. Under either scenario, the reimbursement must be determined based upon the fair and reasonable reimbursement factors established in TWCA 413.011.

The ALJ disagrees with Carriers’ contention that a literal reading of Rule 134.203 renders an absurd result and, thus, should be read to encompass air ambulance services within the 125% of Medicare reimbursement rate in the rule. Specifically, Carriers’ position rests on the argument that Rule 134.203(f) could not apply to air ambulance services because that subsection applies only “[f]or products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division.”¹⁷ Because Medicare has set a rate for air ambulance services, just not in the DMEPOS, Carriers argue that this subsection cannot apply. However, the ALJ finds that the language of subsection (f) must be read in conjunction with the rest of Rule 134.203. This would result in the reference to “relative value unit or payment” in subsection (f) to be understood as referring only to relative value units or payments otherwise covered by the other portions of Rule 134.203. Thus, subsection (f) applies when the other portions of Rule 134.203 do not apply because a relative value unit or payment encompassed within the other portions of Rule 134.203 has not been established.

Regardless, even if the ALJ is incorrect in this reading, the net result is the same: to determine fair and reasonable reimbursement, one must go back to Rule 134.1’s “catch-all” provision and the standards set out in Texas Labor Code § 413.011 for fair and reasonable reimbursement. This is true either because Rule 134.203 does not apply at all, or because it does

¹⁶ Subsections (b) and (c) do not apply, as they do not specifically apply to air ambulance services and also do not set a reimbursement of 125% of Medicare, as requested by Carriers.

¹⁷ 28 Tex. Admin. Code § 134.203(f).

apply and subsection (f) dictates that reimbursement be based upon TWCA § 413.011 and Rule 134.1's fair and reasonable factors. So, the ALJ now turns to the analysis of those factors.

2. Is 125% of Medicare a Fair and Reasonable Reimbursement?

While the parties spend a great deal of time arguing over the framing of the “fair and reasonable” analysis, the case is relatively straightforward and involves one overarching question: Should workers’ compensation reimbursement amounts be higher to “make up” for the significant percentage of PHI’s patients that pay Medicare rates or below?¹⁸

Ultimately, the ALJ concludes that the statutory factors for reimbursement do not allow for workers’ compensation payments to be a source of subsidization for other classes of patients. The statutory factors envision a reimbursement amount that is fair and is designed to address the costs necessary to provide services for the patients covered by workers’ compensation insurance, not to subsidize other classes of patients. However, the reimbursement rates also should not be so low that they require PHI’s other patients to subsidize workers’ compensation patients. With this principle in mind, the ALJ turns to Carriers’ proposed reimbursement rate.

The ALJ finds that Carriers’ proposed reimbursement of 125% of Medicare is not consistent with the statutory standards. It is not fair and reasonable, as it is below the average required revenue amount that has allowed PHI to maintain a limited amount of profitability between 2010 and 2013. Put another way, if every patient that PHI served paid for air ambulance services at 125% of Medicare, PHI would have suffered losses in each of the years between 2010 and 2013. Requiring PHI to operate at a loss is not “fair and reasonable.” Although Carriers argue that the applicable workers’ compensation rules do not guarantee a profit, those rules also do not envision requiring providers to operate at a loss. The terms “fair” and “reasonable” by their very nature should ensure fairness and reasonableness to *all* parties involved—including patients, insurers, and providers. A fair and reasonable rate should allow a fair and reasonable profit to a provider. A rate that requires a provider to operate at a loss is not fair or reasonable unless the provider has been shown to be inefficient.¹⁹ In this case, the ALJ does not find that the evidence demonstrates that PHI is an inefficient provider, has unreasonably high costs, or is obtaining an unreasonably high profit margin.

Further, the ALJ agrees that the rate of 125% of Medicare proposed by Carriers is based solely on a conversion factor to Medicare rates, without consideration of the other statutory factors. This is prohibited by Texas Labor Code § 413.011(b). While Medicare rates should

¹⁸ To be clear, it is often not the patient paying, but simply someone paying on the patient’s behalf—such as a governmental program or other third-party payer.

¹⁹ For example, inefficiency might be shown if a provider incurs significantly higher operating costs than other providers in the same or a comparable market.

serve as a foundation for developing reimbursement rates,²⁰ they cannot be used as the sole basis, even with a conversion factor applied.²¹ To be proper, a reimbursement must be more than simply Medicare, or some conversion factor of Medicare, without regard to the additional factors in the statute. If a conversion factor is applied, it must be developed by taking into account “economic indicators in health care”²² as well as the additional criteria in Texas Labor Code § 413.011(d). In this case, Carriers’ proposed 125% of Medicare was not developed on this basis, but rather was simply developed as a conversion factor of Medicare rates—although Carriers attempted to justify it after the fact by reference to the additional statutory criteria.

However, even Carrier’s after-the-fact evidence via the testimony of Dr. Luke does not support a reimbursement of 125% of Medicare. Dr. Luke’s opinion was that lower rates would be proper (as shown by his testimony that the adjustment factors warranted a reimbursement of 115% to 120% of Medicare for air ambulance transport charges, and 107% to 111% of Medicare for mileage charges). The only way Carriers get to 125% of Medicare is through a straightforward conversion factor based solely upon Carrier’s reliance on Rule 134.203. Because air ambulance services have not been shown to fall within that rule’s 125% of Medicare rate provision, Carriers’ use of it is essentially an impermissible use of a conversion factor.

Finally, because Carriers’ proposed rate of 125% of Medicare would result in losses to PHI if it were adopted across the board for all patients covered by insurance, it is not “designed to ensure the quality of medical care” as required by Texas Labor § 413.011(d). Although Carrier’s expert argues that PHI will continue to accept workers compensation patients even at 125% of Medicare, because such is additional incremental revenue that exceeds marginal variable costs associated with the services, his argument is a bit disingenuous. The statute does not simply indicate that the reimbursement must “ensure” quality medical care for some limited period of time, but it must be “designed to ensure” the provision of quality medical care to workers’ compensation patients, *i.e.*, it must be designed to be a sustainable reimbursement rate over time. This is a key distinction.

Unique situations, such as already sunk fixed costs and/or the fact that workers’ compensation patients make up a very small portion of PHI’s business, may make it feasible for PHI to continue to provide services to those patients at a rate that does not cover the pro rata fixed costs for the services. But such a reimbursement is not objectively “designed” to ensure quality medical care; it is simply a happenstance of PHI’s current financial situation. When the statute requires that a reimbursement rate be designed to ensure quality medical care, the ALJ construes that as a requirement that the reimbursement be designed to be self-sustaining—namely, a reimbursement amount that, standing alone, would incentivize the provision of

²⁰ See, e.g., Texas Labor Code § 413.011(a), which requires that DWC “adopt the most current reimbursement methodologies, models, and values or weights by the federal Centers for Medicare and Medicaid Services.”

²¹ Tex. Lab. Code § 413.011(b).

²² Tex. Lab. Code § 413.011(b).

services. A reimbursement rate of 125% of Medicare would not do this, because it would result in losses to PHI if it were the reimbursement rate applied to all of PHI's patients covered by insurance.

It is this "design" requirement that also justifies consideration of PHI's payer mix. Carriers' expert contends that PHI's payer mix—particularly the patients who pay nothing or very little—is not relevant to determining a fair and reasonable reimbursement rate. The ALJ disagrees. In virtually any business accounting method or regulatory rate-setting scheme, "bad debt" is considered a legitimate business expense that must be accounted for. When considering whether a rate is "designed" to ensure access to quality medical care, the proper accounting of bad debt expenses across a company's payer mix is a proper consideration. Thus, accounting for PHI's payer mix, which by necessity includes PHI's bad debt expenses, is proper.

Therefore, as discussed above, Carriers' proposed rate will not satisfy the statutory factors because it (1) is not fair and reasonable, (2) is simply a conversion factor or other payment adjustment factor based solely on Medicare rates, which is explicitly prohibited by Texas Labor Code § 413.011(b); and (3) is not designed to ensure the quality of medical care, as required by Texas Labor Code § 413.011(d).

Although Carriers' requested rate of 125% of Medicare has not been shown to be a proper reimbursement, the evidence they submitted has demonstrated two other things: (1) PHI's requested reimbursement of billed charges is not consistent with the statutory standards and is not a proper reimbursement amount; and (2) a reimbursement of 149% of Medicare would satisfy the statutory standards and is the proper reimbursement amount for the services at issue.

3. Are Billed Charges a Fair and Reasonable Reimbursement?

The ALJ finds that PHI's billed charges are not a proper reimbursement because they are not consistent with the statutory requirements under the TWCA. The evidence establishes that PHI recovers 125% of Medicare or less from 72% of its patients. As such, paying full billed charges (which are typically at least two to three times the Medicare rate) violates the statutory prohibition that reimbursement amounts generally "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."²³ The TWCA generally prohibits reimbursements that are excessive when compared to the amounts

²³ Tex. Lab. Code § 413.011(d).

paid by equivalent populations.²⁴ A reimbursement rate that is two or three times the amount paid by approximately 72% of PHI's patients would violate this statutory prohibition.

Moreover, a reimbursement rate of billed charges, when 72% of PHI's patients reimburse at much less than this, is not designed to achieve effective medical cost control, as required by Texas Labor Code § 413.011(d). A reimbursement rate that is two or three times the rate paid by 72% of PHI's patients does not achieve effective cost control, but actually incentivizes PHI to seek out more workers compensation patients as a means to subsidize PHI's other patients.

Further, a rate that is two or three times the rate actually paid by 72% of PHI's other patients is not "fair and reasonable" to workers' compensation patients or those who pay on their behalf. Just as the "fair and reasonable" requirement dictates that a provider should not be expected to operate at a loss, it also dictates that workers' compensation patients should not be required to pay two or three times the rates paid by 72% of PHI's patients.

Finally, PHI's proposed reimbursement rate of billed charges does not take into account the increased security of payment afforded by the TWCA, as required by Texas Labor Code § 413.011(d). The implicit purpose of that portion of Texas Labor Code § 413.011(d) is to reflect the understanding that workers' compensation reimbursement rates should be *lower* than rates for many other populations because of the security of payment that comes from the existence of workers' compensation insurance. PHI's proposal would result in workers' compensation reimbursement essentially being the *highest* amount recovered by PHI among its patient populations. While some patient populations, such as those covered by private insurance, would pay similar rates as workers' compensation patients, PHI's billed charges are the highest rates charged by PHI and reflect no discount whatsoever. Basically, workers' compensation patients would be paying "sticker price," while numerous other patient populations are allowed to pay less than that. This is not consistent with Texas Labor Code § 413.011(d).

So, neither Carriers' proposed rate of 125% of Medicare nor PHI's proposed rate of "billed charges" are consistent with the statutory standards. However, evidence in the record does provide an adequate basis to determine a reimbursement amount that is consistent with the statutory standards, and that evidence shows that 149% of Medicare satisfies the applicable criteria.

4. Is 149% of Medicare a Fair and Reasonable Reimbursement?

The evidence shows that 149% of Medicare is the amount that reflects PHI's average cost

²⁴ In its post-hearing arguments, PHI emphasized the word "charged" in Texas Labor Code § 413.011(d), noting that the amount charged, not the amount paid, is what the focus is on when comparing to equivalent populations. However, the sentence goes on to include the language "and paid by that individual or someone acting on that individual's behalf." (emphasis added). Thus, the ALJ concludes that the emphasis is not simply on what was charged, but also what was paid by or on behalf of the equivalent populations.

to provide service to each patient and to attain the profit it has earned the past few years.²⁵ Basically, this is the amount that, if paid by every PHI patient, would allow PHI to operate exactly as it did during the time period at issue, making a profit that Carriers' expert conceded is adequate.²⁶ This rate satisfies the statutory factors. It is fair and reasonable to all parties in that it accounts for PHI's payer mix and ensures recovery of costs and a reasonable profit without requiring workers' compensation patients to pay the highest rates to improperly subsidize the vast majority of PHI's other patient populations.²⁷ Although 149% of Medicare is still higher than the amounts recovered for a large portion of PHI's customer base, it is the most "subsidization-neutral" amount demonstrated by the evidence, and thus does not result in a significant subsidization of other patient populations. It also satisfies the other statutory factors, as set out below.

A rate of 149% of Medicare is not simply a conversion or other payment adjustment factor based solely on those factors as developed by the federal CMS. Although strictly speaking it is based upon the Medicare rate, the 149% adjustment is reached by taking into account PHI's costs, bad debts, and profit; thus, it is not "based solely" on the Medicare reimbursement rate.

Similarly, 149% of Medicare is designed to ensure the quality of medical care. PHI has covered its costs and made a reasonable profit at this average rate for the period between 2010 and 2013. Thus, this amount is designed to encourage PHI and other similar providers to continue to provide services and will ensure the quality of medical care.

The rate of 149% of Medicare is also designed to achieve effective medical cost control. Although it is higher than Medicare, it is significantly lower than the amount billed by PHI and paid by most of PHI's private insurers. It guarantees a reasonable profit, but does not incentivize abuse or excessive charges in the system. Because it is based upon Medicare, it is cost-controlling by design in that it is anchored to a *lower* amount. In contrast, if it were linked to a higher amount—such as if it were a percentage of billed charges—it would provide no cost control, as it would incentivize higher billed charges by providers and provide no theoretical upward limit on the reimbursement.

Also, a rate of 149% of Medicare does not appear to violate the prohibition in Texas Labor Code § 413.011(d) against reimbursement that results in 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." While 149% of Medicare is clearly higher than Medicare, other payment rules in Texas already recognize that

²⁵ Tr. Vol. 2 at 284, 304-05.

²⁶ Tr. Vol. 2 at 329. The parties clarified after the hearing that the pre-tax profit margin for 2010-2013 was approximately 9.15%, with an after-tax margin of approximately 5%.

²⁷ Although the ALJ believes that payer mix is a proper consideration in the analysis, he does not believe it is a driving factor. Rather it is a minor consideration in the fair and reasonable analysis. Thus, providers cannot rely on payer mix as a dominant reason to argue for a higher reimbursement amount, irrespective of the other statutory factors.

the Texas workers' compensation patient population is not exactly an equivalent population to the Medicare population. DWC has provided in Rule 134.203 for reimbursement at 125% of Medicare for many services and products. This would not be permissible if the Medicare population was deemed to be strictly an equivalent population to the Texas workers' compensation population. So, while the two populations are similar in many respects, they are not exactly equivalent, and DWC reimbursement amounts are properly higher than Medicare amounts. Accordingly, the ALJ finds that 149% of Medicare does not result in a fee that violates Texas Labor Code § 413.011(d).

1. Finally, a rate of 149% of Medicare takes into account the increased security of payment afforded by the TWCA. It is less than the amount paid by private insurers or billed to PHI's uninsured patients. Given all of these considerations, the ALJ finds that 149% of Medicare is the proper reimbursement.²⁸

V. CONCLUSION

In conclusion, the ALJ finds that neither Carriers' proposed reimbursement of 125% of Medicare nor PHI's proposed reimbursement of billed charges satisfy the applicable statutory standards. However, the reimbursement rate of 149% of Medicare does satisfy the statutory standards, and that is the amount the ALJ orders be reimbursed by Carriers for the air ambulance services in issue. For each of the 33 cases involved in this joined docket, the parties have submitted a chart reflecting the amounts already paid, the total amount required at the rate of 149% of Medicare, and the remaining balance owed based upon this total amount due. Consistent with that chart, the ALJ finds that PHI is entitled to the amounts shown on the chart, and Carriers shall make payment for the "amount owed" for each case. In support of this conclusion, the ALJ makes the following findings of fact and conclusions of law.

VI. FINDINGS OF FACT

1. PHI Air Medical (PHI) is a licensed air ambulance provider holding an FAA Part 135 certificate and regulated by the U.S. Department of Transportation under the Federal Aviation Act.
2. PHI provides rotary wing air ambulance services from multiple independent bases in Texas, which are not operated as part of a hospital program.
3. PHI transports injured patients by air to trauma centers and other emergency facilities.

²⁸ Rule 134.1 also requires that a reimbursement rate ensures that similar procedures provided in similar circumstances receive similar reimbursement and be based on nationally recognized published studies, published DWC medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available. The ALJ finds these requirements are satisfied by the rate ordered in this case, as it provides a uniform reimbursement for all similarly-situated patients of PHI, across different carriers. It also is based upon Medicare rates, which are based upon nationally-recognized studies. Thus, both additional elements of Rule 134.1 are satisfied.

4. This case involves 33 separate dockets joined together for hearing and issuance of a single decision. Each docket involves the transport of a single patient by PHI.
5. Each of the injured workers in the 33 dockets addressed by this decision was transported by a PHI rotary wing air ambulance (RWAA) between 2010 and 2013.
6. The Texas workers' compensation insurers responsible for reimbursing PHI for the transports involved in this case are Texas Mutual Insurance Company, Twin City Fire Insurance Company, Hartford Casualty Insurance, Hartford Underwriters Insurance Company, Zenith Insurance Company, Transportation Insurance Company, Valley Forge Insurance Company, and TASB Risk Management Fund (collectively, "Carriers").
7. PHI billed each of the Carriers for each RWAA transport at issue in these dockets (i) a per-trip charge and (ii) a mileage charge for the miles PHI transported the patient. PHI billed each charge using its respective Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Level II A code: A0431 for the per-trip charge, and A0436 for the mileage charge. PHI's charges were its usual and customary charges for these services.
8. The Carriers reimbursed PHI at a rate equal to 125% of the Medicare payment rate for each code, under the assumption that the Texas Department of Insurance, Division of Workers' Compensation (DWC) fee guideline published at 28 Texas Administrative Code § 134.203(d)(1) applied and limited reimbursement to 125% of the Medicare reimbursement amount.
9. CMS publishes a Medicare payment rate for codes A0431 and A0436 annually that includes the following components: a standard payment for each code that varies by a Geographic Adjustment Factor (GAF) for each ambulance fee schedule locality area (GPCI), and a 50% add-on for each code for zip codes designated "rural" by CMS. The Medicare payment rate is updated for inflation annually.
10. PHI's charges, the Carriers' payments, and the reimbursement amount at 149% of Medicare in each of the 33 claims in the dockets at issue are attached to this Order at Attachment 1.
11. PHI sought additional reimbursement on each of the 33 claims at issue in these dockets by requesting medical fee dispute resolution (MFDR) with DWC.
12. DWC issued MFDR decisions finding that its jurisdiction was preempted by the federal Airline Deregulation Act (ADA), 49 U.S.C. § 41713(b), and declining to order any reimbursement within the Texas workers' compensation system.
13. DWC's decisions were appealed to the State Office of Administrative Hearings (SOAH) and assigned to Administrative Law Judge (ALJ) Craig R. Bennett.

14. The appeals were consolidated under lead SOAH Docket No. 454-12-7770.M4.
15. In an order dated November 13, 2013, the ALJ concluded that the Texas Workers' Compensation Act (TWCA), including its reimbursement standards, was not preempted by the ADA. Accordingly, on January 15, 2014, the ALJ remanded the cases back to DWC for MFDR on the merits.
16. In each of the cases in issue, DWC conducted MFDR and issued a decision requiring Carriers to reimburse PHI its billed charges as a fair and reasonable reimbursement.
17. Carriers timely appealed DWC's decisions and the cases were again referred to SOAH for a hearing, given new docket numbers, and assigned to ALJ Craig R. Bennett.
18. All parties received adequate notice of the time, place and nature of the hearing; the legal authority and the jurisdiction under which it was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters at issue.
19. On April 22-24, 2015, SOAH ALJ Craig R. Bennett held a contested case hearing in the 33 joined dockets at the William P. Clements Office Building, 300 West 15th Street, Austin, Texas 78701. Texas Mutual Insurance Company appeared through its attorney, Matthew Baumgartner. The other Carriers appeared through their attorney, James Loughlin. PHI appeared through its attorneys, Andres Medrano and Leslie Ritchie Robnett.
20. The record closed on August 27, 2015, after the parties submitted post-hearing briefs, proposed findings of fact and conclusions of law, and financial calculations requested by the ALJ.
21. Between 2010 and 2013, PHI earned a pre-tax profit margin of approximately 9.15% and an after-tax margin of approximately 5%, based on an average transport recovery of 149% of the Medicare reimbursement amount.
22. PHI's profit margin for the period between 2010 and 2013 was fair, reasonable, adequate, and not excessive.
23. A reimbursement of 125% of the Medicare reimbursement amount is equal to or higher than the amount paid by or on behalf of 72% of PHI's patients during the relevant time period.
24. A reimbursement of 125% of the Medicare reimbursement amount for the air ambulance services and mileage charges in issue is not fair and reasonable, within the meaning of the applicable statutes and rules under the TWCA.

25. A reimbursement of PHI's billed charges for the air ambulance services and mileage charges at issue is not fair and reasonable within the meaning of the applicable statutes and rules under the TWCA.
26. Reimbursement at 149% of the Medicare reimbursement amount for the air ambulance services and mileage charges at issue is fair and reasonable within the meaning of the applicable statutes and rules under the TWCA.

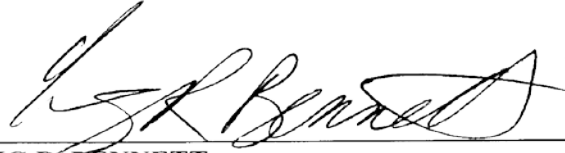
VII. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to Texas Labor Code § 413.031 and Texas Government Code chapter 2003.
2. Adequate and timely notice of the hearing was provided in accordance with Texas Government Code §§ 2001.051 and 2001.052.
3. The TWCA, Texas Labor Code § 401.001, *et seq.*, including the relevant reimbursement requirements, is not preempted by the ADA. A separate federal law, the McCarran-Ferguson Act, 15 U.S.C. § 1011-1015, explicitly reserves the regulation of the business of insurance to the states. Accordingly, reimbursement of the services at issue is governed by the TWCA and the rules applying it.
4. Carriers have the burden of proving by a preponderance of the evidence the proper reimbursement amount to be paid to PHI for the RWAA services provided to the injured workers in the 33 cases involved in this proceeding.
5. There is no maximum allowable reimbursement established by DWC for the air ambulances services and mileage charges at issue. More specifically, 28 Texas Administrative Code § 134.203 does not establish a reimbursement rate of 125% of Medicare for the air ambulance services and mileage charges in issue.
6. The reimbursement rate for the air ambulance services and mileage charges at issue in this case must be determined through application of 28 Texas Administrative Code § 134.1(f) and Texas Labor Code § 413.011.
7. The preponderance of the evidence establishes that the proper reimbursement for the RWAA services at issue, as determined after consideration of the factors in 28 Texas Administrative Code § 134.1(f) and Texas Labor Code § 413.011, is 149% of the Medicare reimbursement amount.
8. PHI is entitled to additional reimbursement from Carriers in the amounts reflected on Attachment 1 to this Decision and Order.

ORDER

IT IS ORDERED that the respective Carriers shall pay PHI the additional reimbursement amounts reflected in the "Amount Owed" column on Attachment 1 for the services provided by PHI to the injured workers involved in each of the 33 dockets addressed in this proceeding.

SIGNED September 8, 2015.

A handwritten signature in black ink, appearing to read "Craig R. Bennett", is written over a horizontal line.

**CRAIG R. BENNETT
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS**