



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

AIR EVAC EMS, INC.

Respondent Name

SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number

M4-15-2603-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

April 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the United States Code Title 49, 41713, the Airline Deregulation Act (ADA) of 1978 states that individual states cannot regulate the prices, routes or services of the air ambulance industry, therefore, it is inappropriate that air ambulance services be subject to state workers' compensation allowance and should be reimbursed at 100% of billed charges."

Amount in Dispute: \$31,714.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel asserts the requestor, Air Evac EMS Inc. is entitled to \$0.00 reimbursement for air ambulance services in dispute based on the requestor's failure to request medical fee dispute resolution no later than one year after the date of service in dispute."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 19, 2014	Air Ambulance Services	\$31,714.20	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 193 – Original payment decision maintained
 - P12 – Workers' Compensation State Fee Schedule Adj
 - W3 – Appeal/Reconsideration
 - 234 – This procedure is not paid separately.
 - RU – Rural Base Rate and Mileage rate

Issues

- 1. Did the requestor waive the right to medical fee dispute resolution?

Findings

- 1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is February 19, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 13, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division’s MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

May 22, 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.