



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

MED-TRANS CORPORATION

Respondent Name

LM INSURANCE CORPORATION

MFDR Tracking Number

M4-16-0142-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been processed with an incorrect fee schedule by [the employer]. 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: \$25,483.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim. . . . The air ambulance charges in dispute were submitted to the employer who issued reimbursement. . . . this dispute is not eligible for the medical fee dispute resolution process."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 2, 2014, Air Ambulance Services, \$25,483.52, \$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

- 1. Texas Labor Code §413.031 provides for medical dispute resolution and review of medical services.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

Issues

Did the requestor waive the right to medical fee dispute resolution?

Findings

Per 28 Texas Administrative Code §133.20(j)(1)(C), a health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the right to medical dispute resolution as provided by Labor Code §413.031. Review of the submitted information finds that the requestor submitted the medical bills for the disputed health care to the injured employee’s employer. The Division therefore concludes that the requestor has waived the right to medical fee dispute resolution.

Conclusion

The requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the medical fee issues have not been addressed. As a result, the amount ordered is \$0.00.

ORDER

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

Authorized Signature

	Grayson Richardson	October 9, 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, 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.