Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANTHONY TRAN MD
3300 MATLOCK ROAD
ARLINGTON TX 76015

Respondent Name
FARMINGTON CASUALTY CO

Carrier's Austin Representative
Box Number 05

MFDR Tracking Number
M4-13-0678-01

MFDR Date Received
November 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am appealing that decision based on the following; The injured employee was referred to Dr. Tran by Concentra, one of your in network providers, for an emergency procedure and because Dr. Tran is the only specialist of this kind in the area."

Amount in Dispute: $9,749.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request for medical fee dispute resolution should be dismissed in accordance with rule 133.307(e)(3)(E) as the provider failed to timely file the request within one year of the disputed dates of service as required by Rule 133.307(c)(1)(A)."

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Ste. A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 20, 2010 through December 22, 2010	Surgical Intervention	$9,749.00	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - HCND – 45 – Charge exceeds fee sch/max allowable or contracted/legislated fee arrangement. You are not an authorized Travelers HCN provider. At this time your services are being denied by the claim adjuster.
   - TXQ7 – 59 – Charges are adjusted based on multiple surgery rules. Multiple surgical procedures billed on the same day will be reimbursed at 100% for the major procedure and 50% for each subsequent procedure.

- PAYF – W1 – Workers compensation state fee schedule adjustment. This procedure/service code is reimbursed based on your state workers' compensation medical fee schedule.
- 013M – 59 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. This charge has been cascaded according to the multiple surgery guidelines.
- INCD – 97 – Payment is included in the allowance for another service/procedure. Included in global reimbursement.
- 16 – Claim/service lacks information which is needed for adjudication.
- DUPQ – These services have already been considered for reimbursement.

Issue

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

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution 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 dates of the service in dispute are October 12, 2010 through December 22, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on November 13, 2012. 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, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

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

Signature	Medical Fee Dispute Resolution Officer	March 28, 2014 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.