



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

DEEPAK V. CHAVDA, MD, PA

Respondent Name

CITY OF FORT WORTH

MFDR Tracking Number

M4-16-0485-01

Carrier's Austin Representative Box

Box Number 04

MFDR Date Received

OCTOBER 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have enclosed a Mail Log of the billing record which is proof that the charges were billed on time. This is a permanent record in our billing system and cannot be modified."

Amount in Dispute: \$416.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor did not submit documentation supporting an exception in §408.0272(b). Based on these rules we did not overturn our previous denials."

Response Submitted by: York Risk Services Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2015	CPT Code 97530-GP (X2) Physical Therapy Services	\$178.00	\$0.00
	CPT Code 97110-GP-59 (X2) Physical Therapy Services	\$176.00	\$0.00
	CPT Code 99211 Office Visit	\$62.40	\$0.00
TOTAL		\$416.40	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.

3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29-The time limit for filing claim/bill has expired.
 - W3-Appeal/reconsideration.

Issue

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

Findings

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29."

Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to the respondent within the 95 day deadline.

The Division finds that the requestor did not submit any documentation to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

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 reimbursement for the disputed services.

Authorized Signature

		11/19/2015
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.