

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

AIRPORT CHIROPRACTIC
PC

Respondent Name

TRAVIS COUNTY

MFDR Tracking Number

M4-22-2819-01

Carrier's Austin Representative

Box Number 38

DWC Date Received

August 31, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 30, 2021	Codes 99215, 98941, 97014 and 97010	\$4,997.00	\$0.00
April 14, 2021	Codes 98941, 97014, 97010, 97012 and 97035		
April 15, 2021	Codes 98941, 97017, 97010, 97012, 97035 and 97140		
April 19, 2021	Codes 98941, 97017, 97010, 97012, 97035 and 97140		
April 22, 2021	Codes 98941, 97014, 97010 and 97012		
April 26, 2021	Codes 98941, 97014, 97010 and 97012		
April 28, 2021	Codes 98941, 97014, 97010, 97012 and 97110		

May 6, 2021	Codes 99215, 97014 and 97010		
April 12, 2021	Codes 98941, 97014, 97010 and 97110		
April 13, 2021	Codes 98941, 97014, 97010, 97012 and 97110		
April 19, 2021	Codes 98941, 97014, 97010, 97012 and 97110		
April 20, 2021	Codes 98940, 97014, 97010, 97012 and 97110		
April 25, 2021	Codes 99212		
April 26, 2021	Codes 98941, 97014, 97010, 97140 and 97110		
April 27, 2021	Codes 98941, 97014, 97010, 97012, 97140 and 97110		
April 31, 2021	Codes 98941, 97012 and 97110		
Total		\$4,997.00	\$0.00

"Please accept and review the attached documentation regarding partial non-payment of claim [claim number] for patient [injured employee]

Attached you will find the following

1. Confirmation of successful fax
2. Fax cover including note to adjust regarding failure to respond
3. Pages 3 – 52 include HCFAs DOS 3/20/21 through 5/31/21, supporting clinic notes and TWCC forms..."

Amount in Dispute: \$4,997.00

Respondent's Position

No insurance carrier response received.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- No explanation of benefits provided

Issues

1. Did the insurance carrier respond to the DWC 60 request in dispute?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The Austin carrier representative for Travis County is Travis County. Travis County was notified of this medical fee dispute on September 07, 2022. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1)
2. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division 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 March 30, 2021 to May 31, 2021. The request for medical fee dispute resolution was received on August 31, 2022. 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; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

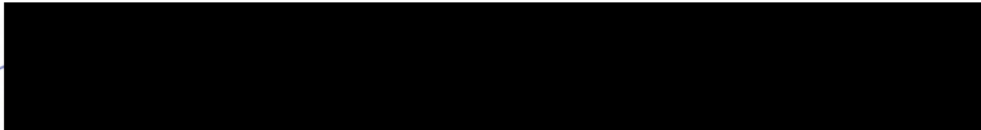
The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds that no additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature



January 6, 2023

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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

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

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.