



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Chirofx

Respondent Name

City of Austin

MFDR Tracking Number

M4-26-1828-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

February 19, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 1, 2025	97039	\$100.00	\$0.00
August 1, 2025	97530	\$85.00	\$0.00
August 1, 2025	97140x2	\$170.00	\$0.00
August 1, 2025	97110	\$85.00	\$0.00
August 1, 2025	97750	\$150.00	\$0.00
August 1, 2025	95831	\$85.00	\$0.00
August 1, 2025	97112	\$85.00	\$0.00
August 1, 2025	0101T	\$350.00	\$0.00
Total		\$1,195.00	\$0.00

Requester's Position

The submitted documentation does not include a position statement from the requester. Accordingly, this decision is based on the information available at the time of adjudication.

Amount In Dispute: \$1,195.00

Respondent's Position

The Austin carrier representative for City of Austin in Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on February 26, 2026.

Per 28 Texas Administrative Code Section 133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [133.20](#) sets out the requirements for medical bill submission.
3. 28 TAC Section [102.4](#) details the general rules for non-division communication.
4. Labor Code Section [408.0272](#) sets out workers' compensation guidelines for timely billing and exceptions.

Adjustment Reasons

Neither party submitted an explanation of benefits for the disputed services.

Issues

1. What is DWC considering in this medical fee dispute?

2. Did the requester support this claim was submitted to the correct insurance carrier within the required timeframe?

Findings

1. The requester submitted a request to MFDR for professional medical services rendered on August 1, 2025 in the amount of \$1,195.00. Neither party submitted a position statement or supported claim submission or adjudication. The review of the applicable DWC rules are shown below.
2. The submitted documentation contained many email notifications to athensbills@athensadmin.com.

28 TAC Section 102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will 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 through 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 must be the next previous day that is not a Sunday or legal holiday.

The time frames in which a claim must be submitted is detailed in 28 TAC Section 133.20 (b) which states in pertinent part,

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Texas Labor Code Section 408.0272. (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation found the email documentation does not indicate a medical claim was submitted to the correct workers compensation carrier for the injured worker in this dispute.

DWC finds there is insufficient information to support any of the exceptions described above apply in this dispute. No payment is recommended.

Conclusion

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

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	<u>June 12, 2026</u>
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 Section [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 800-252-7031, option three 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 this Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

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