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

TEXAS INJURED WORKERS PHARMACY
PO BOX 170624
ARLINGTON TX 76003

Carrier's Austin Representative Box

Box Number 54

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Date Received

JANUARY 13, 2004

MFDR Tracking Number

M4-04-5117-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Said claims have all been submitted for RE-CONSIDERATION but rejected by the carrier. Original EOB'S WERE ALL WITHIN DATE for initial submission and payment consideration to the insurance carrier and within the 365 days from date of service."

Amount in Dispute: $557.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Alternatively, MRD should deny the requestor's request for additional compensation because the requestor has failed to provide the data required to establish its usual and customary charge to customers outside the workers' compensation system for this particular drug."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2002 through December 17, 2002	Prescription Medications (Dates of Services untimely submitted to MFDR)	$557.23	$0.00
January 16, 2003 through May 22, 2003	Prescription Medications		

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 resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.304 sets out the procedures for medical payments and denials.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – Fee guideline MAR reduction.
   - TW – Reduced to estimated usual and customary charge, based on available research, data, Labor Code

Sec. 413.043, and 2002 Pharmacy Fee Guideline, 29 [sic] Tex. Admin. Code 134.503.

- O – Denial after reconsideration.
- YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed.

Issues

1. Did the requestor submit the disputed dates of service timely?
2. Did the requestor submit copies of the DWC-66?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.307(d)(1), effective January 1, 2003, states in part that a request for medical dispute resolution on a carrier denial or reduction of a medical bill shall be considered timely if it is filed with the division no later than one year after the dates of service in dispute. Review of documentation finds that the request for medical fee dispute resolution was received on January 13, 2004; dates of service October 16, 2002 through December 17, 2002 were not submitted timely and cannot be reviewed.
2. In accordance with 28 Texas Administrative Code §133.307(B)(2)(A), effective January 1, 2003, states that each copy of the request shall be legible, include only a single copy of each document, and shall include: a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with §133.304. Review of the documentation submitted finds that the requestor did not include copies of the medical bills as required by the Division.
3. The submitted documentation does not support additional reimbursement is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that additional reimbursement is not 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

Signature	Medical Fee Dispute Resolution Officer	February 20, 2014 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.