



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

American Specialty Pharmacy

Respondent Name

ZNAT Insurance Co

MFDR Tracking Number

M4-16-1740-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

February 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$159.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Should the Texas Department of Insurance Division of Workers' Compensation permit the provider's MFDR Request submission; Zenith's position is that no payment is due to the provider as the disputed services should have been billed through TMESYS."

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2015	Pharmacy Services	\$159.20	\$0.00

FINDINGS AND DECISION

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

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out the requirements for submission of medical bills.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - DPS XX – TMESYS processes Zenith's pharmacy bills. Please submit your bill to TMESYS using one fo the methods outlined below
 - 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline

Issues

1. Is the carrier’s position supported?
2. Did the requestor meet requirements of Division rules that pertain to billing?

Findings

1. The respondent states in their position statement, “American Specialty Pharmacy did not comply with Rule §133.250 Reconsideration for Payments of Medical Bills as only one bill submission was received for the disputed services.” 28 Texas Administrative Code §133.307(f)(3)(A) states in pertinent part,

The division will review the completed request and response to determine appropriate MFDR action.

(3) Dismissal. A dismissal is not a final decision by the division. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of this section. The division may dismiss a request for MFDR if:

(A) the division determines that the medical bills in the dispute have not been submitted to the insurance carrier for an appeal, when required;

Pursuant to the above referenced rule states, “the Division may dismiss a request for MFDR...” In this instance, the Division will not dismiss but rather review the request based on the appropriate rules and fee guidelines

2. 28 Texas Administrative Code Rule §133.20 (b) states in pertinent part,

...the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

Review of the submitted documentation finds the following:

- Health care provided faxed a claim to carrier on January 21, 2016
- Carrier notified health care provider on January 26, 2016 of correct carrier and where and how to submit the claim to the correct carrier

The Division finds insufficient evidence to support the health care provider submitted a claim to the correct carrier upon notification. Therefore as billing requirements of Rule 133.20 were not met, no additional payment can be 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April , 2016
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, 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 MFDR 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.