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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Managed Pharmacy Program

Respondent Name
Vanliner Insurance Co

MFDR Tracking Number
M4-16-1982-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Services were provided in good faith in accordance to the guidelines in the state of Texas."

Amount in Dispute: $231.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because Requestor has failed to submit documentation showing its contract with Target Pharmacy to act as Target Pharmacy's processing agent, Requestor has failed to prove it has standing as a requestor at medical Fee Dispute Resolution. For this reason, Requestor has failed to establish it is owed any monies."

Response Submitted by: Downs ♦ Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2015 October 23, 2015	Pharmacy Services	$231.39	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 183 – Payment adjusted because procedure/service was partially or fully furnished by another provider
   - 185 – The rendering provider is not eligible to perform the service billed
   - 58 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline

Issues

1. Did the requestor support their right to participate in the MFDR process?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(P) states,

   > if the requestor is a pharmacy processing agent, a signed and dated copy of an agreement between the processing agent and the pharmacy clearly demonstrating the dates of service covered by the contract and a clear assignment of the pharmacy's right to participate in the MFDR process.

Managed Pharmacy Programs did not clearly demonstrate that the dates of service in dispute were covered by a contract with Target Pharmacy that clearly assigns the right for Managed Pharmacy Programs to participate in the MFDR process. The respondent's position statement is supported.

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 26, 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.