



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

Memorial Compounding Pharmacy

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-18-2541-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

March 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on claim/service lacks information or has submission/billing error(s) which is needed for adjudication."

Amount in Dispute: \$479.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2017	Meloxicam	\$479.89	\$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 §134.502 sets out the requirements for submitting pharmacy bills.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

Issues

- 1. Did the carrier respond to the medical fee dispute?
- 2. Was the service in dispute submitted with valid NDC?

Findings

- 1. The Austin carrier representative for the Carrier is Downs Stanford. Downs Stanford acknowledged receipt of the copy of this medical fee dispute on March 20, 2018.

28 Texas Administrative Code §133.307 states, in relevant part:

- (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
 - (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of Indemnity Insurance Co of North American from Downs Stanford to date.

The division concludes that the Carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

- 2. The requestor is seeking reimbursement for medication dispensed on July 28, 2017 for the amount of \$479.89. The carrier denied as 16 – “Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Review of the submitted DWC066 finds NDC 38779-2376-01 in box 21. The division finds that NDC 38779237601 is not a valid National Drug Code (NDC) as required by 28 Texas Administrative Code §134.502(d)(1).

The carrier’s denial is supported. No additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		July 24, 2018

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *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. **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.