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
Memorial Compounding Pharmacy

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-18-3927-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
June 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the explanation of benefits it indicates that carrier paid $0.00 and not the full amount of $479.89."

Amount in Dispute: $479.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2017	Meloxicam 100%	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for billing pharmaceutical services.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the service in question?

Findings

Memorial is seeking reimbursement of $479.89 for Meloxicam 100%, billed using NDC #38779237601, dispensed on June 14, 2017. The insurance carrier denied the disputed service with claim adjustment reason code 181 – "Procedure code was invalid on the date of service." The DWC finds that NDC #38779237601 is not a valid NDC as required by 28 Texas Administrative Code §134.502(d)(1). Therefore, Memorial is not entitled to reimbursement for the disputed service.

Conclusion

For the reasons stated above, the DWC 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

	Laurie Garnes	January 18, 2019
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 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.