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
Insurance Company of the State of PA

MFDR Tracking Number
M4-19-1792-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Document control number … states that code **(29),** based on **(TIME LIMIT FOR FILING CLAIM/BILL HAS EXPIRED)** is the new denial reason."

Amount in Dispute: $522.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the requestor's submitted documentation the initial medical bill was submitted on 05/24/18 for date of service 05/16/18; billed amount $179.83. A bill review was conducted under bill ide#2451498 and final action rendered with payment in full on 06/05/18.

On 10/16/18 Memorial Compounding RX submitted a medical bill for date of service 05/16/18; billed amount $522.85 … a bill review was conducted on the new bill and final action was rendered on 10/31/18 based on CARC code 29: Time Limit for Filing Claim/Bill has Expired."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2018	Compound Medication	$522.85	$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. 28 Texas Administrative Code §133.20 sets out the procedures for submission of a medical bill.
3. Texas Labor Code §408.027 sets out the requirements regarding payment of a health care provider.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Notes: "Effective 9/1/15, providers have 95 days to submit bills to the insurance carrier for reimbursement. Your bill exceeds this limit. Reimbursement is denied in accordance with Section 408.027 of the Act."
   - 29 – Time Limit for Filing Claim/Bill has Expired

Issues

Is the requestor entitled to reimbursement for the compound ingredients in this dispute?

Findings

Memorial is seeking reimbursement for a compound dispensed on May 16, 2018, consisting of the following ingredients:

- Baclofen
- Amantadine HCl
- Gabapentin USP
- Bupivacaine HCl

Memorial was required to submit a complete medical bill for the ingredients in question to the insurance carrier within 95 days from the date of service.[1] Per explanation of benefits dated October 31, 2018, the insurance carrier received the bill for the disputed ingredients on or about October 16, 2018. This date is more than 95 days after the date of service.

No evidence was presented to support that a bill for the ingredients included in this dispute were submitted to the insurance carrier prior to October 16, 2018. No reimbursement 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

	Laurie Garnes	January 9, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.20(b); Texas Labor Code §408.027(a)

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.