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 RX

Respondent Name
United Airlines Inc

MFDR Tracking Number
M4-21-0047-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 11, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the original bill as well, and the reconsideration based on pre=authorization."

Amount in Dispute: $180.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor bill for a medication using NDC code 59316020510. However, that code is not valid in Texas."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2020	Biofreeze4% roll-on	$180.50	$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 §134.503 sets out the guidelines for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 936 – This code is either deleted, non-covered, bundled, invalid or the status indicator is not allowable under the provider's jurisdiction
   - 181 – Procedure code was invalid on the date of service

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of Biofreeze Roll-on billed with NDC 59316-0205-10. The insurance carrier denied the disputed service as invalid code. The NDC number could not be found. The insurance carrier's denial is supported.

No payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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

		October 9, 2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.