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
M4-21-0146-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 29, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per Rule…"

Amount in Dispute: $288.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor bill for a medication using NDC code 59316-0205-10. However, that code is not valid in Texas. Therefore, the medication was denied due to the use of an invalid code."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2020	Biofreeze 4% Roll-on	$288.50	$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. 28 Texas Administrative Code 28 TAC §133.20 sets on requirements of medical bill submission.
4. The insurance carrier denied the disputed service with the following remark codes.
   - 936 – This code is either deleted, non-covered, bundled, invalid of the status indicator is not allowable

under the providers jurisdiction
- 161 – Procedure code was invalid on the date of the service.

Issues

Is the insurance carrier's denial supported?

Findings

The requestor is seeking reimbursement of medication dispensed in June 2020. The insurance carrier denied as the National Drug Code (NDC) was invalid.

28 TAC §134.503 (b) states in pertinent part, for coding billing, reporting and reimbursement of prescription drugs and nonprescription drugs or over -the-counter medications Texas workers' compensation system participants shall apply the provisions of Chapters 133 and 134.

28 TAC §133.20 (c) states a health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

Review of the submitted NDC number found no records. 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 22, 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.