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
XL Insurance America Inc

MFDR Tracking Number
M4-21-0193-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 6, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was denied on 07/15/2020 00663 based on fee schedule. An appeal was submitted 08/08/2020. See attached 2 denials for processing. In addition, the explanation of benefits states the Peer Review is the new denial reason. …the carrier cannot change from the original denial."

Amount in Dispute: $259.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for XL Insurance America Inc is Flahive Ogden & Latson who was notified of this medical fee dispute on October 13, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2020	Oral medication	$259.90	$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 billing requirements for medical claims.

Issues

1. Is the requestor's position statement supported?
2. Did the requestor support submission of the claim to the correct carrier?

Findings

1. The requestor is seeking reimbursement of oral medication dispensed June 25, 2020. The requestor states in their position, "The original claim was denied on 07/15/2020 00663 based on fee schedule. An appeal was submitted 08/08/2020. See attached 2 denials for processing." Insufficient evidence was found to support these statements from the requestor. These statements will not be considered in this review.

2. 28 TAC §133.20 states in pertinent part except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. The insurance carrier that is responsible for the disputed claim is XL Insurance America. The documentation submitted by the requestor indicates billing sent to Gallagher Bassett. Insufficient evidence found to support submission of this claim to the correct carrier within timeline required by rule.

   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

		December 28, 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.