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
Texas Department of Transportation

MFDR Tracking Number
M4-21-1595-01

Carrier's Austin Representative
Box Number 32

MFDR Date Received
May 10, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $202.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Under the process of bill audit a determination was made the Tax ID submitted on the bill was not a match to the name in box 4 of the DWC066. Six attempts were made thru phone calls to the provider for a current W9 clarifying the name charge. Due to no response from the provider the bill was returned by mail with a letter of explanation requesting the information. No response was received from the provider."

Response submitted by: Injury Management Organization, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 25, 2021	Meloxicam	$202.85	$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 §133.10 sets out the requirements for submission of medical claim.

Issues

Is the insurance carriers' position supported?

Findings

The requestor is seeking reimbursement of oral medication dispensed January 25, 2021. The insurance carrier states, "the Tax Id submitted on the bill was not a match to the name in box 4 of the DWC066."

28 TAC §133.10 (3) states in pertinent part, "The following date content or data elements are required for a complete pharmacy medical bill (A) dispensing pharmacy's name and address, (F) payee's federal employer identification number (DWC-066/filed 6) is required."

The insurance carrier has made numerous attempts to obtain the required information from the requestor. Based on no response from the requestor a complete pharmacy medical bill was not submitted per DWC guidelines. 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

		June17, 2021
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.