



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Memorial Compounding  
RX

**Respondent Name**

State Office of Risk Management

**MFDR Tracking Number**

M4-23-1126-01

**Carrier's Austin Representative**

Box Number 45

**DWC Date Received**

January 16, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 8, 2022	00603-2213-32	\$75.60	\$0.00
September 8, 2022	29300-0125-10	\$202.85	\$0.00
September 8, 2022	31722-0533-05	\$71.98	\$0.00
September 8, 2022	62175-0136-43	\$258.21	\$0.00
<b>Total</b>		<b>\$608.64</b>	<b>\$0.00</b>

### Requestor's Position

"The original bill was submitted to carrier on 09/12/2022. 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 45<sup>th</sup> day after the date of receipt by the carrier. Memorial did not receive any correspondence as per Rule 133.250(a)."

**Amount in Dispute:** \$608.64

### Respondent's Position

"Further review of the dispute packet did locate the fax confirmation sheet acknowledging the receipt of the 2 pages for the OTC Acetaminophen on 09/12/2022 however this fax did not include the other medication as mentioned above. There is no clear documentation to support

that the certified mail receipts listed as evidence in this dispute file with a received date of 10/31/2022 are for the medications in this dispute. To date, we are not in receipt of a DWC66 for the Amitriptyline – NDC 00603-22136-32, Meloxicam – NDC 293000-0125-10, Methocarbamol – NDC 31722-0533-05 and Omeprazole – NDC 62175-0136-43.”

**Response Submitted by:** State Office of Risk Management

## **Findings and Decision**

### Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers’ Compensation (DWC).

### Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.20 sets out requirements of medical bill submission.
3. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.

### Denial Reasons

Neither party submitted copies of explanation of benefits to support adjudication of this claim.

### Issues

1. Did the requestor support timely submission of medical claim?

### Findings

1. The requestor is seeking reimbursement for oral medications dispensed in September 2022. The requestor presented a fax confirmation sheet dated September 11, 2022 indicating the successful transmission of two pages. The requestor also included a certified mail receipt indicating “appeal 09/08/22” and a “Second Proof” showing receipt of certified mail on October 31, 2022, by the Office of the Attorney General.”

DWC Rule TAC §133.20 (b) states in pertinent part,

(b) 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.

Texas Labor Code 408.0272. (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation found the document "First Proof" supports only two pages sent. The DWC66 included in the packet was three pages plus a cover sheet would have been four pages.

The second proof shows receipt of certified mail by the Attorney General's Office. This information does not support either an exception as detailed above or the successful submission of the claim within the required time frame.

No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is [not] entitled to additional reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

February 28, 2023  
\_\_\_\_\_  
Date

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).