



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Injured Workers Pharmacy

Respondent Name

North River Insurance Co

MFDR Tracking Number

M4-25-2835-01

Carrier's Austin Representative

Box Number 53

DWC Date Received

July 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 2, 2025	27241009990	\$592.87	\$0.00
April 2, 2025	16714008311	\$119.80	\$0.00
	Total	\$712.67	\$0.00

Requester's Position

"The attached bill was submitted electronically through a clearing house (Jopari), we confirmed with Cadence RX which is the carrier's preferred vendor, and they advised there has been no response from the carrier. I reached out to the adjuster for an update and there has been no response."

Amount in Dispute: \$712.67

Respondent's Position

"The bill for date of service 04/02/2025 was not received until 07/10/2025 (MFDR receipt date). Zenith's Claims Examiner has confirmed that the provider was timely informed regarding authorization for date of service 04/02/2025. Therefore, the bill for date of service 04/02/2025 has been correctly denied as untimely filed pursuant to TX Rule 133.20. Pursuant to Rule 133.20(b) and Section 408.027(a), Injured Workers Pharmacy, LLC has forfeited the right to reimbursement due to untimely submission of the medical bill. No payment is due to this date

of service.”

Response Submitted by: The Zenith

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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §133.20](#) sets out requirements of medical bill submission.
3. [28 TAC §102.4](#) details the general rules for Non-Division Communication.
4. [Texas Labor Code 408.0272](#) sets out the workers compensation timely billing and exceptions guidelines.

Denial Reasons

The insurance carrier denied the disputed services with the following claim adjustment codes.

- 200 – Per 133.20, a medical bill shall not be submitted later than the 1st day of the 11th month (<08/31/05 or 95 days (>09/01/05) after DOS.
- 29 – The time limit for filing has expired.

Issues

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

Findings

1. The requester is seeking reimbursement of prescription medications dispensed in April of 2025. The insurance carrier denied the disputed charges as claim not submitted timely. The requester states, “The attached bill was submitted electronically through a clearing house (Jopari)...”

DWC Rule 28 TAC §102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on:

- (1) the date received if sent by fax, personal delivery, or electronic transmission; or
- (2) the date postmarked if sent by mail through United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written

communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent must be the next previous day that is not a Sunday or legal holiday.

DWC Rule 28 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 insufficient evidence to support the requester's statement that a claim was successfully transmitted to the correct workers' compensation carrier.

Also, DWC finds there is insufficient information to support an exception described above. No payment is recommended.

Conclusion

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

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 15, 2025

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. 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.

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.