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
Continental Casualty Company

MFDR Tracking Number
M4-18-0867-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**The original bill was submitted to carrier on 07/27/2017 via CERTIFIED MAIL** … Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration … The request was submitted and received by the carrier on **09/23/2017 via CERTIFIED MAIL still with no response.**"

Amount in Dispute: $609.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In reviewing the documentation attached to the DWC60 Request, the date of injury is referenced as [redacted] for Carrier, Bershire Hathaway Homestate … To date, Carrier has not received medical billing for this Date of Service and therefore has not processed any EORs."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2017	Pharmacy Services	$609.67	$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 medial bill submission procedures for health care providers.
3. The submitted documentation did not include explanations of benefits.

Issues

Did Memorial Compounding Pharmacy (Memorial) submit a bill for the services in question in accordance with 28 Texas Administrative Code §133.20?

Findings

Memorial is seeking reimbursement of $609.67 for Gabapentin, Meloxicam, Acetaminophen/Codeine, and Cyclobenzaprine dispensed on July 18, 2017. Brian J. Judis asserted on behalf of Continental Casualty Company, "To date, Carrier has not received medical billing for this Date of Service and therefore has not processed any EORs."

28 Texas Administrative Code §133.20(a) states, "The health care provider shall submit all medical bills **to the insurance carrier** except when billing the employer in accordance with subsection (j) of this section."

The division finds that the insurance carrier for the claim in question is Continental Casualty Company. Review of the submitted documentation does not support that Memorial sent the bills for the disputed services to Continental Casualty Company, its agent, or the employer, in accordance with 28 Texas Administrative Code §133.20. For this reason, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement 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

	Laurie Garnes	February 1, 2018
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 the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.