



# 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 RX

**Respondent Name**

Twin City Fire Insurance Company

**MFDR Tracking Number**

M4-19-0113-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

September 7, 2018

#### 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:** \$566.53

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "... in order to resolve this matter and preclude the time and expense involved with the continued litigation of this matter, Twin City will pay the disputed charges in accordance with the appropriate guidelines."

**Response Submitted by:** Burns Anderson Jury & Brenner

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12, 2018	Compound Medication	\$566.53	\$566.53

#### 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 (DWC).

**Issues**

Is Memorial Compounding Rx (Memorial) entitled to reimbursement for the dispute in question?

**Findings**

Memorial is seeking reimbursement for a compound medication dispensed on March 12, 2018. In its response to this medical fee dispute, the insurance carrier did not maintain a denial of payment for this medication.

No evidence of the payment referenced in the insurance carrier’s response was received by the DWC. The DWC finds that Memorial is entitled to reimbursement of this medication.

The reimbursement for the medication in question is calculated according to Texas Administrative Code §134.503 as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Meloxicam	38779274601	G	\$194.67	0.18	\$43.80	\$35.04	\$35.04
Flurbiprofen	38779036209	G	\$36.58	4.8	\$219.48	\$175.58	\$175.58
Tramadol	38779237409	G	\$36.30	6	\$272.25	\$217.80	\$217.80
Cyclobenzaprine	38779039509	G	\$46.33	1.8	\$104.25	\$83.39	\$83.39
Bupivacaine	38779052405	G	\$45.60	1.2	\$68.40	\$54.72	\$54.72
						Total	\$566.53

The total allowable reimbursement is \$566.53. This amount is recommended.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$566.53.

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor \$566.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Date

March 20, 2020

**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.**