



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

Old Republic Insurance Company

MFDR Tracking Number

M4-19-4080-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

May 8, 2019

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: \$217.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2019	Gabapentin 300 mg Capsules	\$217.05	\$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 (DWC).

Background

1. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. The documentation submitted to the DWC does not include explanations of benefits.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. The Austin carrier representative for Old Republic Insurance Company is White Espey, PLLC. White Espey, PLLC acknowledged receipt of the copy of this medical fee dispute on May 16, 2019. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. A health care provider is required to submit a medical bill to the insurance carrier no less than 95 days from the date of service or waive its right to reimbursement.¹

Memorial submitted certified mail receipts to support that the medical bill considered in this dispute was submitted to the insurance carrier. Review of the documents finds that the tracking numbers of the submissions and receipts do not match. Therefore, the submitted documentation does not support that the health care provider submitted a medical bill for the service in question to the insurance carrier or its agent not less than 95 days from the date of service.

The DWC concludes that Memorial is not entitled to reimbursement for the examination in question.

Conclusion

For the reasons stated above, the DWC 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 DWC hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	September 19, 2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 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.

¹ 28 TAC §133.20(b); Texas Labor Code §408.027(a)