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
Allen ISD

MFDR Tracking Number
M4-19-4455-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was denied on **03/29/2019** (HE83) based on (**DUPLICATE CLAIM**). **An appeal** was submitted on **05/01/2019**. See attached 2 denials for processing. In addition, CHECK number (CHECK #0002244452) on the explanation of benefits does not show a denial code, so there is no way to determine the new denial reason."

Amount in Dispute: $66.19

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
March 15, 2019	Methocarbamol 500 mg Tablets	$66.19	$14.86

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
   - HE83 – Duplicate Paid/Captured Claim

Issues

1. Did Allen ISD respond to the medical fee dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. The Austin carrier representative for Allen ISD is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on June 18, 2019. 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.[1]

   As of today, no response has been received from the insurance carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

2. Memorial is seeking reimbursement for Methocarbamol 500 mg tablets dispensed on March 15, 2019. The insurance carrier denied payment based on a duplicate claim. No evidence was presented to the DWC to support that this bill was a duplicate. Therefore, the insurance carrier's denial of payment is not supported.

3. Because the insurance carrier failed to support its denial of payment for the disputed drug, Memorial is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[2]:

   - Methocarbamol 500 mg tablets: (0.4825 x 18 x 1.25) + $4.00 = $14.86

   The total reimbursement is therefore $14.86. 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 $14.86.

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 $14.86, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 25, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.307(d)(1)

[2] 28 Texas Administrative Code §134.503(c)

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.