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 RX

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-20-0126-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
September 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original bill was submitted to carrier on **06/28/2019 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 **08/08/2019 via certified mail** still with no response."

Amount in Dispute: $271.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This claim is denied in its entirety."

Response Submitted by: Smith & Carr, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2019	Methocarbamol 500 mg Tablets	$71.98	$22.09
June 10, 2019	Naproxen 500 mg Tablets	$130.31	$95.01
June 10, 2019	Meclizin 25 mg Tablets	$69.54	$19.05
	Total	$271.83	$136.15

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 submitted documents did not include explanations of benefits.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. In its position statement, Smith & Carr, P.C., on behalf of the insurance carrier, argued that "This claim is denied in its entirety."

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.[1]

   The submitted documentation does not support that a denial based on compensability was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Because the insurance carrier failed to support a denial of payment for the drugs in question, Memorial is entitled to reimbursement. The fees are calculated as follows:[2]

   - Methocarbamol 500 mg Tablets: (0.4825 x 30 x 1.25) + $4.00 = $22.09
   - Naproxen 500 mg Tablets: (1.2135 x 60 x 1.25) + $4.00 = $95.01
   - Meclizine 20 mg Tablets: (0.4014 x 30 x 1.25) + $4.00 = $19.05

   The total allowable amount for the drugs in this dispute is $136.15. 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 $136.15.

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 $136.15, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 3, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] 20 TAC §134.503(c)(1)

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.