



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

Arch Indemnity Insurance Company

MFDR Tracking Number

M4-20-0842-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 14, 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: \$187.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Compensability Dispute is unresolved."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include August 14, 2019 for Ibuprofen 800 mg Tablets and Tramadol HCl 50 mg Tablets, and a Total row.

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 §133.240 sets out the procedures for payment or denial of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.503 sets out the fee guidelines for pharmaceutical services.
4. No explanations of benefits were submitted with this dispute.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. In its position statement, Flahive, Ogden & Latson, on behalf of the insurance carrier, argued that “The Compensability Dispute is unresolved.”

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 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 gave no denial reason for the drugs in this dispute prior to MFDR, the DWC finds that Memorial is entitled to reimbursement.

The reimbursement considered in this dispute is calculated as follows²:

- Ibuprofen 800 mg tablets: $(0.8049 \times 60 \times 1.25) + \$4.00 = \$64.37$
- Tramadol HCl 50 mg tablets: $(0.79615 \times 30 \times 1.25) + \$4.00 = \$33.86$

The total allowable reimbursement is \$98.23. 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 \$98.23.

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 \$98.23, 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 31, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

¹ 28 Texas Administrative Code §133.307(d)(2)(F)

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.