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
BRIDGEFIELD CASUALTY INSURANCE

MFDR Tracking Number
M4-20-2414-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 4, 2020

REQUESTOR'S POSITION SUMMARY

"Bill for date of service **02/25/2020** was processed and paid incorrectly."

Amount in Dispute: $509.96

RESPONDENT'S POSITION SUMMARY

"The medication was not authorized; and therefore, payment is not owed."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2020	Duloxetine	$509.96	$509.96

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 denied payment prior to the request for medical fee dispute of the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment. This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. Did Bridgefield Casualty Company raise a new defense in its response?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. In its position statement, Bridgefield Casualty Company, on behalf of the insurance carrier, argued that "The medication was not authorized; and therefore, payment is not owed."

   The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before to 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 preauthorization 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 Bridgefield Casualty Company failed to support its denial reason for the service in this dispute, the DWC finds that Memorial is entitled to reimbursement.

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

   - Duloxetine HCl DR 30 mg Capsules: (7.541 x 60 x 1.25) + $4.00 = $569.58

   The total allowable reimbursement is $569.58. Memorial is seeking $509.96. 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 $509.96.

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 $509.96, 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	July 24, 2020 Date

[1] 28 TAC §133.307 (d)(2)(F)
[2] 28 TAC §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.