



# 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**

XL SPECIALTY INSURANCE CO

**MFDR Tracking Number**

M4-20-2987-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

August 24, 2020

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Then on 08/06/2020, document control number [REDACTED] on the explanation of benefits states that the payment has now been reversed."

**Amount in Dispute:** \$204.14

#### 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
May 27, 2020	Cyclobenzaprine 5 mg Tablets	\$106.72	\$65.52
May 27, 2020	Gabapentin 300 mg Capsules	\$97.42	\$53.90
Total		\$204.14	\$119.42

#### 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 a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

## **Issues**

1. Did XL Specialty Insurance Company respond to the medical fee dispute?
2. Is this dispute subject to dismissal based on extent of the compensable injury?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

## **Findings**

1. The Austin carrier representative for XL Specialty Insurance Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on September 3, 2020. 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.<sup>1</sup>

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. The insurance carrier denied the compound, in part, based on extent of the compensable injury. A dispute regarding extent of injury must be resolved prior to a request for medical fee dispute.<sup>2</sup>

The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves compensability or liability. No PLN was received for this dispute. This dispute is not subject to dismissal as the denial reason was not supported.

3. Memorial is seeking reimbursement for drugs dispensed on May 27, 2020. The DWC reviewed the submitted documents.

Memorial submitted an explanation of benefits dated July 29, 2020. This document indicates that the review agent recommended payment of \$119.43 and then reversed that payment in the same document. No documents were submitted to support payment by the insurance carrier.

Based on the documentation provided, the DWC finds that there is insufficient evidence that the insurance carrier reimbursed the drugs in question or provided a reason for denial as required by 28 TAC §133.240(f).

Because the insurance carrier failed to sufficiently support a denial of reimbursement or that the bill was paid, Memorial is entitled to reimbursement.

The reimbursement considered in this dispute is calculated as follows<sup>3</sup>:

- Cyclobenzaprine 5 mg Tablets:  $(1.6405 \times 30 \times 1.25) + \$4.00 = \$65.52$
- Gabapentin 300 mg Capsules:  $(1.3307 \times 30 \times 1.25) + \$4.00 = \$53.90$

The total allowable reimbursement is \$119.43. 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 \$119.43.

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<sup>1</sup> 28 TAC §133.307(d)(1)

<sup>2</sup> 28 Texas Administrative Codes §§133.305(b) and 133.307(c)(1)(B)(i)

<sup>3</sup> 28 Texas Administrative Code §134.503(c)

**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 \$119.43, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

_____	_____	December 16, 2020
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.**