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
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-21-0695-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
December 21, 2020

REQUESTOR'S POSITION SUMMARY

"The original claim was denied on **09/30/2020** based on **NO DENIAL CODE**. An appeal was submitted on **10/25/2020**. See attached 2 denials for processing. In addition, document control number (DCN #:) on the explanation of benefits states that **ALTERNATE VENDOR** is the new denial reason."

Amount in Dispute: $145.41

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Old Republic Insurance Company is White Espey, PLLC. The representative was notified of this medical fee dispute on December 29, 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.[1]

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2020	Tizanidine	$145.41	$113.89

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.

[1] 28 TAC §133.307(d)(1)

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D3(P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
   - NRCN – The bill has been reconsidered and no additional money is due.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

Memorial is seeking reimbursement for drugs dispensed on August 6, 2020.

Explanation of benefits dated November 20, 2020, indicates that the review agent recommended payment of $113.89 and then reversed that payment in the same document.

Based on the documentation provided, DWC finds that there is insufficient evidence that the insurance carrier reimbursed the drug in question.

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[2]:

- Tizanidine HCl 4 mg tablets: (1.4652 x 60 x 1.25) + $4.00 = $113.89

The total allowable reimbursement is $113.89. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 $113.89.

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 $113.89, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		May 4, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

[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.