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
M4-21-0754-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
January 8, 2021

REQUESTOR'S POSITION SUMMARY

"Memorial Compounding has provided service and met all requirements to receive reimbursement."

Amount in Dispute: $179.68

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
September 24, 2020	Cyclobenzaprine 5 mg Tablets	$106.72	$65.52
September 24, 2020	Ibuprofen 600 mg Tablets	$72.96	$23.32
	Total	$179.68	$88.84

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 reduced payment for the disputed services with the following claim adjustment codes:
   - 60 (B13) – The provider has billed for the exact service on a previous bill.

Issues

1. Did Old Republic Insurance Company respond to the medical fee dispute?
2. Is the insurance carrier's denial of payment supported?
3. Is Memorial Compounding Rx (Memorial) entitled to reimbursement?

Findings

1. The Austin carrier representative for Old Republic Insurance Company is White Espey, PLLC. The representative was notified of this medical fee dispute on January 12, 2021. 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.

2. Memorial is seeking reimbursement for drugs dispensed September 24, 2020. The insurance carrier denied payment stating, "The provider has billed for the exact service on a previous bill." No evidence was submitted to support this denial reason.

3. Because Old Republic Insurance 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]:

   - Cyclobenzaprine HCl 5 mg tablets: (1.6405 x 30 x 1.25) + $4.00 = $65.52
   - Ibuprofen 600 mg tablets: (0.5153 x 30 x 1.25) + $4.00 = $23.32

   The total allowable reimbursement is $88.84. 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 $88.84.

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 $88.84, 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	May 4, 2021 Date

[1] 28 TAC §133.307(d)(1)
[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.