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
Berkshire Hathaway Homestate Insurance Co

MFDR Tracking Number
M4-21-1759-01

Carrier's Austin Representative
Box 12

MFDR Date Received
June 2, 2021

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: $1,226.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Requestor alleges that it initially faxed the bill to Respondent on 03/10/21, but did not receive payment or an explanation of benefits (EOB). Requestor sent a "request for reconsideration" to Respondent on 04/07/21. …However, neither the bill nor the request for reconsideration were sent to the proper bill review agent. It appears Requestor sent the request to Berkshire Guard, which is a separate entity from Respondent. Given Requestor's use of an incorrect fax number, Respondent did not receive Requestor's "original" bill. In fact, the first notice Respondent had of the services and resultant bills was 06/07/21 when it received a copy of Requestor's Request for Medical Fee Dispute Resolution from the Division. Requestor has not issue a bill or requested payment from Respondent as required by Rule 133.20(b)."

Response submitted by: Shanley Price

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2021	Oral medication	$1,226.59	$0.00

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission.

Issues

Did the requestor support timely submission of the disputed claim?

Findings

The requestor is seeking $1,226.59 for oral medication dispensed in February 2021. The insurance carrier states the first claim submission was with the request for medical fee dispute as the fax number referenced by the requestor is not valid for the responsible insurance carrier.

Review of the submitted documentation was insufficient to support the claim was received by the carrier, Berkshire Hathaway Homestate Insurance. No payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July 2, 2021
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,

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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.