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 Pharmacy

Respondent Name
Arch Insurance Company

MFDR Tracking Number
M4-18-3125-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have attached the EOB's as well as the documentation to prove that Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $126.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached EOBs. The Requestor has not shown entitlement to payment by this Carrier."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2017	MAPAP Arthritis Pain 650 mg Tablets	$59.60	$6.63
April 28, 2017	Amitriptyline HCl 10 mg Tablets	$66.55	$15.31
	Total	$126.15	$21.94

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 §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:
   - 18 – Exact duplicate claim/service.
   - 23 – The impact of prior payer(s) adjudication including payments and/or adjustments

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Are Arch Insurance Company's reasons for denial of payment supported?
2. Is Memorial Compound Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. Memorial is seeking reimbursement for MAPAP Arthritis Pain 650 mg tablets and Amitriptyline HCl 10 mg tablets dispensed on April 28, 2017. The insurance carrier denied reimbursement citing that a previous payment decision was made and being maintained. See 193 denial reason above. Although the carrier is required to provide a paper copy of all initial and appeal EOBs in its response to medical fee dispute, in this case the carrier did not do so.[1] The DWC is unable to establish **what** the carrier's "original payment decision" was; and we are also unable to establish whether the carrier issued an explanation of benefits to Memorial within the 45th day from the date it received the original medical bill for the service in dispute.[2]

   The carrier's denial reasons are therefore not supported.

2. Because the insurance carrier failed to support its denial of payment, Memorial is entitled to reimbursement. The reimbursement is calculated as follows[3]:

   - MAPAP Arthritis Pain 650 mg tablets: (0.0701 x 30 x 1.25) + $4.00 = $6.63
   - Amitriptyline HCl 10 mg tablets: (0.3016 x 30 x 1.25) + $4.00 = $15.31

   The total allowable reimbursement amount is $21.94. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $21.94.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $21.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 17, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.307(d)(2)(B)
[2] 28 Texas Administrative Code §133.240
[3] 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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.