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
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-18-3711-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill for date of service **09/27/2017** was processed on **12/27/2017**. **BILL ID #2044-882375** indicated that they **allowed $0.00 DUE TO PAYMENT AS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.** As of today, **we still haven't received this check**."

Amount in Dispute: $132.46

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
September 27, 2017	Tramadol HCL 50 mg Tablets	$132.46	$97.70

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:
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247 – A payment or denial has already been recommended for this service.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement?

Findings

1. The insurance carrier's Austin representative acknowledged receipt of the copy of this medical fee dispute on June 12, 2018. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. If a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.[1]

   No response has been received on behalf of Indemnity Insurance Company of North America to date. For that reason, the decision will be based on the information available.

2. The insurance carrier denied the disputed service based on a previous payment or review. No evidence of a previous payment, reduction, or denial was received. For this reason, Memorial is entitled to reimbursement. The reimbursement is calculated as follows[2]:

   - Tramadol HCL 50 mg tablets: (0.83289 x 90 x 1.25) + $4.00 = $97.70

   The total allowable reimbursement amount is $97.70. 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 $97.70.

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 $97.70, 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 15, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.307(d)(1)
[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 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.