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**
Standard Fire Insurance Company

**MFDR Tracking Number**
M4-18-4931

**Carrier's Austin Representative**
Box Number 5

**MFDR Date Received**
August 14, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The above claimant received medication as prescribed by referral provider … It looks like the carrier processed the claim but never issued a payment to our facility."

**Amount in Dispute:** $202.85

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Claimant's referral doctor, Dr. Lee prescribed a 30 day supply of 15 mg Meloxicam on 01-05-2018. A week later, Dr. Lee's PA, Sarah NGO issued an identical script for Meloxicam. The Claimant filled both scripts, Dr. Lee's with this Provider and Ms. NGO's with [another provider] … As the Carrier had already reimbursed another provider for this prescription, the Provider in this Request for Medical Fee Dispute Resolution is not entitled to reimbursement for the same service."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 5, 2018 | Meloxicam 15 mg tablets | $202.85 | $185.69 |

## *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 §133.260 sets out the procedures for requests for refunds.
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.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Duplicate Claim/Service

**Issues**

1. Is the insurance carrier's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

**Findings**

1. Memorial is seeking reimbursement for Meloxicam 15 mg tablets dispensed on January 5, 2018. The insurance carrier denied the drug as a duplicate service.

   The insurance carrier provided documentation indicating that another pharmacy filled the same drug on January 12, 2018 as evidence that the drug in question is a duplicate. The DWC finds that the documentation provided does not support that the dispense of the drug on January 5, 2018 is a duplicate service. The DWC finds that the drug dispensed on January 12, 2018 is immaterial for this dispute.

   The DWC finds that the denial of payment for the drug in question is not supported.

2. Because the insurance carrier failed to support its denial of payment, Memorial is entitled to reimbursement for the drug in question.

   The reimbursement considered in this dispute is calculated as follows[1]:

   - Meloxicam 15 mg tablets: (185.69 x 30 x 1.25) + $4.00 = $185.69

   The total reimbursement is therefore $185.69. 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 $185.69.

***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 $185.69, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Laurie Garnes | April 18, 2019 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

[1] 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**.