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
Merged Royal Insurance Company of America Into Arrowwood Indemnity

MFDR Tracking Number
M4-18-5004-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
August 16, 2018

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: $274.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Utilization review was completed on 11-14-2016 by Prium for the Tizanidine 4 mg and was certified. I will forward the 01-18-2018 bill to our PBM/bill processer for prompt review and consideration … Utilization review was completed on 10-05-2015 by Prium for the Naproxen 500 mg and was certified. I will forward the 01-18-2018 b ill to our PBM/bill processer for prompt review and consideration."

Response Submitted by: Arrowpoint Capital

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2018	Naproxen 500 mg Tablets	$129.07	$93.46
January 18, 2018	Tizanidine HCl 4 mg Tablets	$145.41	$113.89
	Total	$274.48	$207.35

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 submitted documentation does not include explanations of benefits.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled for reimbursement of the drug in question?

Findings

Memorial is seeking reimbursement for Naproxen 500 mg tablets and Tizanidine HCl 4 mg tablets dispensed on January 18, 2018. The insurance carrier did not present evidence that a denial of payment or reimbursement was provided to Memorial for the drugs in question.

Therefore, the division finds that Memorial is entitled to reimbursement for the drugs in question. The reimbursement for the drugs considered in this dispute is calculated as follows[1]:

- Naproxen 500 mg tablets: (1.1928 x 60 x 1.25) + $4.00 = $93.46
- Tizanidine HCl 4 mg tablets: (1.46524 x 60 x 1.25) + $4.00 = $113.89

The total reimbursement is therefore $207.35. 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 $207.35.

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 $207.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	March 13, 2019
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, 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.

[1] 28 Texas Administrative Code §134.503(c)