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
Texas Mutual Insurance Company

MFDR Tracking Number
M4-18-5172-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It looks like the carrier processed the claim but never issued a payment to our facility."

Amount in Dispute: $360.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Meloxicam was paid … The Tramadol was filled on 2/16/18, quantity 90, and as a 30 day supply. Texas Mutual received a bill from the on 2/27/18 for date 2/23/18 for another quantity of 30 for a 30 day supply. Texas Mutual declined to issue payment as the 30 day supply issued by the requester on 2/16/18 was not due to expire until 3/16/18."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 23, 2018	Tramadol HCl 50 mg Tablets	$157.45	$0.00
February 23, 2018	Meloxicam 15 mg Tablets	$202.85	$0.00
	Total	$360.30	$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 §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:
   - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.

- CAC-154 – Payer deems the information submitted does not support this day's supply.
- CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- PC4 – Payment reduced to Cypress Care Contract rate.
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline.
- 856 – Early refill: documentation has not been submitted to substantiate dispensing this medication prior to previous Rx being exhausted.
- CAC-18 – Exact duplicate claim/service
- 224 – Duplicate charge

Issues

1. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for Tramadol HCl 40 mg tablets?
2. Is Memorial entitled to additional reimbursement for Meloxicam 15 mg tablets?

Findings

1. Memorial is seeking reimbursement for Tramadol HCl 40 mg tablets, quantity 120, dispensed on February 23, 2018. Texas Mutual Insurance Company (Texas Mutual) denied the drug based on early refill, stating that the previous dispense had not expired.

   Memorial has the burden to support its request for this reimbursement of this drug. In its position statement and after notification by the division's medical fee dispute resolution program of the insurance carrier's response, Memorial did not take the opportunity to refute Texas Mutual's expressed denial of payment.

   For that reason, the division moves to resolve the dispute of this drug with the information available and concludes that no additional reimbursement can be recommended.

2. Memorial is also seeking reimbursement for Meloxicam 15 mg tablets, quantity 30, dispensed on February 23, 2018. Review of the explanations of benefits dated March 21, 2017, finds that the insurance carrier issued a payment for Meloxicam 15 mg tablets in the amount of $3.16 to Memorial. The division concludes that Memorial has received payment for the drug in question.

   The carrier reduced the billed amount to a total payment of $3.16 for Meloxicam 15 mg tablets citing the workers' compensation fee schedule as its reason for the reduction. Rule at 28 Texas Administrative Code §134.503(c) applies and states, in pertinent part, that the insurance carrier shall reimburse the lesser of: (1) the fee established by the division's applicable formula based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed; or (2) the amount billed to the insurance carrier.

   Memorial is requesting reimbursement in the amount of $202.85 for this drug. Memorial has the burden to support its request for this amount. In its original position statement, Memorial did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503(c).

   After notification by the division's medical fee dispute resolution program of the carrier's response and payment, Memorial did not take the opportunity to refute the carrier's payment calculation for Meloxicam 15 mg tablets. For that reason, the division moves to resolve the dispute of this drug with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement 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

	Laurie Garnes	March 21, 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.