



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

New Hampshire Insurance Company

MFDR Tracking Number

M4-19-0871-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 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: \$71.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per the attached EOBs, the treatment at issue was not prescribed by the network treating doctor or at the treating doctor's referral or approval."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2018	Tramadol-Acetaminophen 37.5-325 mg Tablets	\$71.84	\$21.93

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. Texas Labor Code §408.021 establishes entitlement to medical benefits.
4. Texas Insurance Code §1305.101 defines the duties of networks to provide medical treatment.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 38 – Services not provided or authorized by designated (network/primary care) providers.
 - 881 – Payment is denied because the service was performed by provider outside the client's MPN Network.

Issues

1. Is New Hampshire Insurance Company's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drugs?

Findings

1. Memorial is seeking reimbursement for Tramadol-Acetaminophen 37.5-325 mg tablets dispensed on May 22, 2018. The insurance carrier because the drug was provided outside the certified health care network.

Prescription medication may not, directly or through a contract, be delivered through a workers' compensation health care network.¹

The division concludes that the disputed prescription medication dispensed by the provider in this case – Memorial Compounding Pharmacy – is not subject to the provisions of a workers' compensation health care network. New Hampshire Insurance Company's denial for this reason is not supported.

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

The reimbursement considered in this dispute is calculated as follows²:

- Tramadol-Acetaminophen 37.5-325 mg tablets: $(1.02436 \times 14 \times 1.25) + \$4.00 = \$21.93$

The total reimbursement is therefore \$21.93. 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 \$21.93.

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 \$21.93, 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 1, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

¹ Texas Insurance Code §1305.101(c)

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.