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
Hartford Casualty Insurance Company

MFDR Tracking Number
M4-19-1219-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As of today, we still haven't received this check or a proper explanation of denial."

Amount in Dispute: $132.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "PLN 11 filed 09/22/17 … ESI issued a denial on 04/13/18."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2018	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 §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. Memorial is seeking reimbursement for Tramadol HCl 50 mg tablets dispensed on March 14, 2018. In its position statement, The Hartford, on behalf of the insurance carrier, asserted "PLN 11 filed 09/22/17 … ESI issued a denial on 04/13/18."

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.[1]

   The submitted documentation includes a bill processed by an agent of the insurance carrier, but does not support that any denial reason was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider the presented argument in the current dispute review.

2. Because the insurance carrier failed to support its denial of reimbursement, Memorial is entitled to reimbursement. The calculation of the total allowable amount is as follows:

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

   The total reimbursement is therefore $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	April 23, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.307(d)(2)(F)

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.