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
Old Republic Insurance Company

MFDR Tracking Number
M4-19-1620-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
November 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original bill was submitted to carrier on **07/27/2018 via certified mail** … Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration … The request ws submitted and received by the carrier on **10/19/2018 via certified mail still** with no response … The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $612.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been disputed as the medication was not preauthorized as required per rule 134.530 and 134.540. The provider has not provided any proof of preauthorization and thus the compound medication has not been paid."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2018	Hydrocodone/APAP 1/325 Tablets	$174.87	$150.72
July 17, 2018	Tramadol HCl ER 100 mg Tablets	$198.71	$180.51
July 17, 2018	Tizanidine HCl 4 mg Tablets	$101.46	$58.95
July 17, 2018	Gabapentin 300 mg Capsules	$137.34	$103.80
	Total	$612.38	$493.98

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 §133.240 sets out the procedures for payment or denial of a medical bill.

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 guidelines.
4. The submitted documentation did not include an explanation of benefits for the billed services in question.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drugs?

Findings

Memorial is seeking reimbursement for Hydrocodone/APAP 10/325 tablets, Tramadol HCl ER 100 mg tablets, Tizanidine HCl 4 mg tablets, Gabapentin 300 mg capsules.

The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information. [1]

The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was submitted on or about July 27, 2018.

No evidence was provided to support that Old Republic Insurance Company took final action on the bill for the drugs in question. Therefore, Memorial is entitled to reimbursement for the services considered in this dispute, in accordance with relevant statutes and rules.

The reimbursement for the drugs considered in this dispute is calculated as follows[2]:

- Hydrocodone/APAP 10/325 mg tablets: (0.97812 x 120 x 1.25) + $4.00 = $150.72
- Tramadol HCl 100 mg tablets: (4.707 x 30 x 1.25) + $4.00 = $180.51
- Tizanidine HCl 4 mg tablets: (1.46524 x 30 x 1.25) + $4.00 = $58.95
- Gabapentin 300 mg capsules: (1.3307 x 60 x 1.25) + $4.00 = $103.80

The total reimbursement is therefore $493.98. 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 $493.98.

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 $493.98, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	January 25, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.240(a)
[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.