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
American Casualty Company of Reading PA

MFDR Tracking Number
M4-19-2237-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
December 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding is an approved provider and should be reimbursed accordingly."

Amount in Dispute: $236.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding CPT codes 60505-0252-02 (previously paid on 11/26/18 in the amount of $113.89) and 00093-0350-05 which was billed for Date of Service 06/27/2018, the Carrier is researching the additional information provided by the Healthcare provider for possible resolution of the disputed services."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2018	Tizanidine HCl 4 mg Tablets	$145.41	$113.89
June 27, 2018	Acetaminophen/Codeine #4 Tablets	$90.61	$45.39
	Total	$236.02	$159.28

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.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

5. Texas Insurance Code §1305 provides the guidelines for certified health care networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 242 – Services not provided by network/primary care providers.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for Tizanidine HCl 4 mg tablets and Acetaminophen/Codeine #4 Tablets dispensed on June 27, 2018. The insurance carrier denied the disputed drugs stating that the services were not provided by a network or primary care provider.

   The division finds 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.[1] Therefore, the insurance carrier's denial for this reason is not supported.

2. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

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

   - Tizanidine HCl 4 mg tablets: (1.46524 x 60 x 1.25) + $4.00 = $113.89
   - Acetaminophen/codeine #4 tablets: (0.55186 x 60 x 1.25) + $4.00 = $45.39

   The total reimbursement is therefore $159.28. 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 $159.28.

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 $159.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	February 8, 2019 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.