TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Liberty Insurance Corporation

MFDR Tracking Number
M4-19-2594-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 14, 2019

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: $1,127.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It was denied as not medically necessary following completion of a retrospective medical necessity review."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2018	Celecoxib 200 mg Capsules	$512.38	$512.38
September 5, 2018	Gabapentin 600 mg Tablets	$208.70	$193.00
September 5, 2018	Omeprazole DR 20 mg Capsules	$315.51	$315.51
September 5, 2018	Acetaminophen/Codeine #4 Tablets	$90.61	$45.39
	Total	$1,127.20	$1,066.28

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 (DWC).

Background

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
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 services.

4. The submitted documentation does not include explanations of benefits.

Issues

1. Did the insurance carrier take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on September 4, 2018. Memorial stated that

   > The original bill was submitted to carrier on **09/11/2018 via fax confirmation** … Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration … The request was submitted and received by the carrier on **11/20/2018 via certified mail** still with no response.

   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 received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

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

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

   - Celecoxib 200 mg capsules: (0.7.58136 x 60 x 1.25) + $4.00 = $572.60
     Memorial is seeking $512.38. This amount is recommended for this drug.
   - Gabapentin 600 mg tablets: (2.52 x 60 x 1.25) + $4.00 = $193.00
   - Omeprazole DR 20 mg capsules: (4.3002 x 60 x 1.25) + $4.00 = $326.52
     Memorial is seeking $315.51. This amount is recommended for this drug.
   - Acetaminophen/Codeine #4 tablets: (0.55186 x 60 x 1.25) + $4.00 = $45.39

   The total reimbursement is therefore $1,066.28. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,066.28.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $1,066.28, 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	October 11, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.