



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

United Airlines, Inc.

MFDR Tracking Number

M4-19-2798-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 22, 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: \$600.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Memorial Compounding Rx is an 'in-network' provider with a PBM ... Memorial should send its bill directly to the PBM ... In this case, Memorial dropped the bill to paper and sent directly to the Carrier."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|--------------------|----------------------------|-------------------|------------|
| September 30, 2018 | Lenzapatch 4%-1% | \$267.50 | \$232.90 |
| September 30, 2018 | Gabapentin 300 mg Capsules | \$177.26 | \$153.70 |
| September 30, 2018 | Cyclobenzaprine HCl 10 mg | \$155.78 | \$126.85 |
| Total | | \$600.54 | \$513.45 |

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:
- 242 – Services not provided by network/primary care providers.

Issues

1. Is the insurance carrier’s denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drugs?

Findings

1. Memorial is seeking reimbursement for drugs dispensed September 30, 2018. The insurance carrier denied the disputed drugs stating that they were “not provided by network/primary care providers”

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

The documentation submitted by Memorial, includes a statement that the claimant “received Medication as prescribed by referral provider.” The insurance carrier failed to support that the prescribing doctor was not the primary care physician or a referral from the primary care physician.

The insurance carrier’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:

- Lenzapatch 4%-1%: $(42.0 \times 5 \times 1.09) + \$4.00 = \$232.90$
- Gabapentin 300 mg capsules: $(1.3307 \times 90 \times 1.25) + \$4.00 = \$153.70$
- Cyclobenzaprine 10 mg tablets: $(1.092 \times 90 \times 1.25) + \$4.00 = \$126.85$

The total reimbursement is therefore \$513.45. 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 \$513.45.

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 \$513.45, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

| | | |
|-----------|--|---------------------------|
| _____ | <u>Laurie Garnes</u> | <u>September 10, 2019</u> |
| 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 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.