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
Continental Insurance Company

MFDR Tracking Number
M4-19-3552-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
March 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding is an approved provider and should be reimbursed accordingly. The referral provider has been treating the patient for the injury sustained at work."

Amount in Dispute: $71.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The doctor prescribing the medications that claimant is requesting reimbursement for is not an approved treating doctor and therefore not authorized to fill medications for this injury."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2018	Ibuprofen 600 mg Tablets	$71.92	$19.72

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:
   - 184 – The prescribing/ordering provider is not eligible to prescribe/order the service billed.

Issues

1. Is Continental Insurance Company's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drug?

Findings

1. Memorial is seeking reimbursement for Ibuprofen 600 mg tablets dispensed on October 22, 2018. The insurance carrier because the drug was provided outside the certified health care network.

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

   The division 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. Continental Insurance Company'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 drug in question.

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

   - Ibuprofen 600 mg tablets: (0.2403 x 60 x 1.09) + $4.00 = $19.72

   The total reimbursement is therefore $19.72. 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 $19.72.

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 $19.72, 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 18, 2019
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 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.