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
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-19-3658-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 1, 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: $615.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2018	Etodolac 500 mg Tablets	$146.30	$115.00
November 15, 2018	Tramadol HCl 50 mg Tablets	$107.47	$66.47
November 15, 2018	Tramadol HCl ER 300 mg Tablets	$361.70	$361.70
	Total	$615.47	$543.17

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 §133.210 sets out the documentation requirements for medical bills.
2. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. Texas Insurance Code 1305 sets out the requirements for certified health care networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service

- Note: "BILLING MUST GO THRU THE PBM – OPTUM"

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Did Memorial Compounding Pharmacy (Memorial) submit a bill to the insurance company?
3. Is the insurance carrier's reason for denial of payment supported?
4. Is Memorial entitled to reimbursement for the disputed drugs?

Findings

1. The Austin carrier representative for Indemnity Insurance Company of North America is Downs Stanford, PC. Downs Stanford, PC acknowledged receipt of the copy of this medical fee dispute on April 10, 2019. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. On explanations of benefits dated November 30, 2018, the insurance carrier stated, "BILLING MUST GO THRU THE PBM – OPTUM."

   The DWC considers any documentation submitted to be simultaneously possessed by the insurance carrier and its agents, and it is the insurance carrier's responsibility to provide its agents with any documentation needed to adjudicate a medical bill.[1]

   The DWC concludes that Memorial submitted a medical bill to the insurance carrier as required in 28 Texas Administrative Code §133.240.

3. The insurance carrier denied the drugs in question based on the network status of the health care provider. Pharmacy services may not be delivered through a healthcare network and are subject to reimbursement through the Texas Workers' Compensation Act.[2]

   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. Therefore, the insurance carrier's denial for this reason is not supported.

4. 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[3]:

   - Etodolac 500 mg tablets: (1.48 x 60 x 1.25) + $4.00 = $115.00
   - Tramadol HCl 50 mg tablets: (0.839 x 60 x 1.25) + $4.00 = $66.47
   - Tramadol HCl ER 300 mg tablets: (10.14 x 30 x 1.25) + $4.00 = $384.25

   The total reimbursement is therefore $543.17. 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 $543.17.

[1] 28 Texas Administrative Code §133.210(e)
[2] Texas Insurance Code §1305.101(c)
[3] 28 Texas Administrative Code §134.503(c)

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 $543.17, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 30, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

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.