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 RX

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-4096-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial has met the requirements to receive reimbursement."

Amount in Dispute: $723.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of MDR, the bill was sent for reconsideration. Once the bill has been processed for payment, I will file an addendum with the EOR and the payment screen."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 7, 2019	Cyclobenzaprine 5 mg Tablets	$160.86	$133.20
February 7, 2019	Meloxicam 7.5 mg Tablets	$247.62	$241.65
February 7, 2019	Omeprazole DR 20 mg Capsules	$315.51	$315.51
	Total	$723.99	$690.36

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

Issues

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

Findings

1. Memorial is seeking reimbursement for drugs dispensed on February 7, 2019. Per explanations of benefits dated February 21, 2019, and April 18, 2019, the insurance carrier denied the drugs in question based on relatedness to the compensable injury.

   The insurance carrier is required to submit a Plain Language Notice (PLN) with its response to the medical fee dispute.[1] No PLN has been received for this dispute.

   In its position statement, ESIS claimed, "Upon receipt of MDR, the bill was sent for reconsideration. Once the bill has been processed for payment, I will file an addendum with the EOR and the payment screen."

   To date, no addendum has been received. Therefore, based on the information provided, the DWC finds that the denial of payment based on relatedness to the compensable injury was not supported.

2. Because the insurance carrier failed to support its denial of payment for the drugs in question, Memorial is entitled to reimbursement. The fees are calculated as follows:[2]

   - Cyclobenzaprine 5 mg Tablets: (1.7226 x 60 x 1.25) + $4.00 = $133.20
   - Meloxicam 7.5 mg Tablets: (3.1687 x 60 x 1.25) + $4.00 = $241.65
   - Omeprazole DR 20 mg Capsules: (43002 x 60 x 1.25) + $4.00 = $326.52
     Memorial is seeking $315.51 for this drug. This amount is recommended for this drug.

   The total allowable amount for the drugs in this dispute is $690.36. 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 $690.36.

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 $690.36, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	November 15, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.307(d)(2)(H)
[2] 20 TAC §134.503(c)(1)

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.