



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

Texas Mutual Insurance Company

MFDR Tracking Number

M4-19-4332-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill for date of service (01/28/2019) was denied for EARLY REFILL. The medication was dispending in a timely manner."

Amount in Dispute: \$143.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The pharmacy previously submitted a bill for Tizanidine HCL Tabs MG with a 10 day supply on 1/25/19, therefore a refill would be on or after 2/2/19. Gabapentin Caps MG on 1/25/19 with a 30 day supply, refill date on 2/17/19. Texas Mutual issued payment for both prescriptions, the provider did not submit documentation to warrant an early refill 3 days after the initial bill and date filled."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include January 28, 2019 for Gabapentin and Tizanidine, and a Total row.

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• CAC-154 – Payer deems the information submitted does not support this day's supply.

- 856 – Early refill: documentation has not been submitted to substantiate dispensing this medication prior to previous RX being exhausted.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration

Issues

Are the insurance carrier’s reasons for denial of payment supported?

Findings

Memorial Compounding Pharmacy (Memorial) is seeking reimbursement for Gabapentin 100 mg capsules and Tizanidine HCl 2 mg tablets dispensed on January 28, 2019.

Texas Mutual Insurance Carrier (Texas Mutual) denied reimbursement of this drug stating that it was an early refill. In its position statement, Texas Mutual asserted that Tizanidine HCl 2 mg tablets with a 10-day supply had also been dispensed on January 25, 2019. Texas Mutual also asserted that Gabapentin 100 mg capsules with a 30-day supply had also been dispensed on January 25, 2019.

The requestor in a medical fee dispute is directed to submit any documentation required to support discusses, demonstrates, and justifies the fee it is seeking.¹ Memorial failed to present any evidence that the prescriber of the drug in question approved a refill of the drugs in question as required by the US Department of Justice, Drug Enforcement Agency.²

Because Memorial failed to support its eligibility for reimbursement, Texas Mutual’s denial of payment is supported. No reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>September 19, 2019</u>
Signature	Medical Fee Dispute Resolution Officer	Date

¹ 28 TAC §133.307(c)(2)

² https://www.deadiversion.usdoj.gov/pubs/manuals/pract/pract_manual012508.pdf#search=refills%20schedule%20v

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.