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
BITCO GENERAL INSURANCE CORP

MFDR Tracking Number
M4-20-0910-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding is an approved provider and should be reimbursed accordingly."

Amount in Dispute: $293.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The prescribing physician is not in the Network. The prescribed treatment has not been approved by the treating physician."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2019	Cyclobenzaprine 10 mg Tablets	$90.25	$44.93
August 21, 2019	Meloxicam 15 mg Tablets	$202.85	$185.69
	Total	$293.10	$230.62

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.
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 August 21, 2019. 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 follows[2]:

   - Cyclobenzaprine 10 mg tablets: (1.0915 x 30 x 1.25) + $4.00 = $44.93
   - Meloxicam 15 mg tablets: (4.845 x 30 x 1.25) + $4.00 = $185.69

   The total reimbursement is therefore $230.62. 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 $230.62.

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 $230.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 31, 2019 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.