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
Norguard Insurance Co

MFDR Tracking Number
M4-20-0957-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
December 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The explanation of benefits was not accompanied with a PLN11 of the denial and date filed."

Amount in Dispute: $615.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2019	Oral medication	$615.80	$440.75

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 pharmacy fee guideline.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 219 – Based on extent of injury

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Memorial is seeking reimbursement for oral medication dispensed August 12, 2019. Gallagher Bassett denied the medication based on extent of injury. The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves extent of injury.

   Review of the submitted documentation finds no evidence of a related PLN on behalf of the insurance carrier to support a denial based on extent of injury.

   The dispute in question is not subject to dismissal due to the lack of PLN11.

2. 28 134.503 states in pertinent part the reimbursement is the lesser of the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed and the amount billed.

   - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

Medication	NDC	Units	AWP	Billed amount	Allowed amount
Meloxicam	29300012410	60	$3.17	$247.62	$241.65
Omeprazole	62175011843	30	$3.37	$259.00	$130.50
Cyclobenzaprine	10702000610	30	$1.72	$109.18	$68.60

3. The billed amount was $615.80. The total allowed amount is $440.75. The lesser amount of $440.75 is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $440.75.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $440.75, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

________________________	________________________	February 7, 2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.