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
Truck Insurance Exchange

MFDR Tracking Number
M4-20-1237-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
January 17, 2020

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $220.19

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
October 16, 2019	Cyclobenzaprine 10 mg Tablets	$90.25	$44.93
October 16, 2019	Ibuprofen 800 mg Tablets	$129.94	$94.55
	Total	$220.19	$139.48

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 §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 131 – Claim specific negotiated discount.
   - 243 – Services not authorized by network/primary care providers.
   - 401 – Workers' compensation non-subscriber adjustment.

Issues

1. Did Truck Insurance Exchange respond to the medical fee dispute?
2. Is the dispute subject to dismissal based on network status?
3. Is Memorial Compounding Rx (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. The Austin insurance carrier representative for Truck Insurance Exchange is Farmers Insurance Group. The representative received the copy of this medical fee dispute on January 27, 2020. 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.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Memorial is seeking reimbursement for drugs dispensed on October 16, 2019. Truck Insurance Exchange denied the drug based on network authorization.

   Prescription medication or services may not be directly or through a contract, be delivered through a workers' compensation health care network.[2]

   The DWC concludes that the disputed prescription medication dispensed by the provider in this case – Memorial Compounding Rx – is not subject to the provisions of a workers' compensation health care network. Therefore, this dispute is not subject to dismissal based on the insurance carrier's denial for this reason.

3. Because Truck Insurance Exchange failed to support its denial reason for the service in this dispute, the DWC finds that Memorial is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[3]:

   - Cyclobenzaprine 10 mg Tablets: (1.09150 x 30 x 1.25) + $4.00 = $44.93
   - Ibuprofen 800 mg Tablets: (0.80490 x 90 x 1.25) + $4.00 = $94.55

   The total allowable reimbursement is $139.48. 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 $139.48.

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 $139.48, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

____________________	Laurie Garnes	March 26, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.307(d)(1)
[2] Texas Insurance Code §1305.101 (c)
[3] 28 TAC §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.