



# 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**

AMERICAN CASUALTY CO OF READING

**MFDR Tracking Number**

M4-20-1957-01

**Carrier's Austin Representative**

Box Number 57

**MFDR Date Received**

April 13, 2020

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The original bill was submitted and received to carrier **01/20/2020** ... Memorial did not receive any correspondence as per Rule 133.250 (a) we submitted a Request for Reconsideration ... The carrier denied the reconsideration based on **ALTERNATIVE VENDOR. Memorial Compounding Pharmacy does not have a contract with Alternative Vendor therefore claim should be processed by the direct carrier.**"

**Amount in Dispute:** \$847.07

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The issue of medical necessity has been joined, and the disputed services have not yet been determined to be medically necessary and appropriate."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2020	Duloxetine HCl DR 20 mg capsules	\$267.20	\$266.13
January 14, 2020	Gabapentin 600 mg tablets	\$284.30	\$284.30
January 14, 2020	Hydrocodone-Acetaminophen 7.5-325 mg tablets	\$295.57	\$295.57
Total		\$847.07	\$846.00

### 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**

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

**Issues**

1. Did the insurance carrier raise a new defense in its response?
2. Is Memorial Compounding Rx (Memorial) entitled to reimbursement for the drugs in question?

**Findings**

1. In its position statement, Flahive, Ogden & Latson, on behalf of the insurance carrier, argued that “The issue of medical necessity has been joined.”

The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before to the request for medical fee dispute resolution (MFDR) was filed with the DWC. Any new denial reasons or defenses raised shall not be considered in this review.<sup>1</sup>

No evidence was submitted to support that a denial based on medical necessity was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Because the insurance carrier failed to support any denial reason for the drugs in this dispute, the DWC finds that Memorial is entitled to reimbursement.

The reimbursement considered in this dispute is calculated as follows<sup>2</sup>:

- Duloxetine HCl DR 20 mg capsules:  $(6.99 \times 30 \times 1.25) + \$4.00 = \$266.13$
- Gabapentin 600 mg tablets:  $(2.52 \times 90 \times 1.25) + \$4.00 = \$287.50$   
Memorial is seeking \$284.30 for this drug. This amount is recommended.
- Hydrocodone-Acetaminophen 7.5-325 mg tablets:  $(2.64522 \times 90 \times 1.25) + \$4.00 = \$301.59$   
Memorial is seeking \$295.57 for this drug. This amount is recommended.

The total allowable reimbursement is \$846.00. 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 \$846.00.

***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 \$846.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	Date
		April 30, 2020

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<sup>1</sup> 28 TAC §133.307 (d)(2)(F)  
<sup>2</sup> 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.**