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

Requester Name
MEMORIAL COMPOUNDING RX

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-20-2634-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 6, 2020

REQUESTER'S POSITION SUMMARY

"These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $72.87

RESPONDENT'S POSITION SUMMARY

"We have reviewed your dispute and found that the payment was issued on 04/17/20 in the amount of $23.21 under check #[redacted] …"

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2020	Tramadol-Acetaminophen 37.5	$72.87	$0.00

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

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4282 – Drugs identified with a status of "Y" in the current edition of the "official disability guidelines treatment in workers' comp" (ODG)/Appendix A, "ODG Workers' Compensation Drug Formulary" identify a drug that can dispensed without preauthorization. The allowance has been determined in according to the pharmacy fee guidelines.
   - B12 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

Memorial is seeking additional reimbursement for Tramadol-Acetaminophen dispensed March 27, 2020. Per explanation of benefits dated April 17, 2020, the insurance carrier reduced the billed amount to a total payment of $23.21 citing the workers' compensation fee schedule as its reason for the reduction.

The insurance carrier is required to pay the lesser of the DWC's pharmacy formulary 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, or the billed amount.[1]

Memorial is requesting an additional reimbursement of $72.87 for the disputed drug. Memorial has the burden to support its request for this amount. Memorial did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503 (c) in its position statement.

After notification by the DWC's medical fee dispute resolution program of the insurance carrier's response and payment, Memorial did not take the opportunity to refute the carrier's payment calculation. The DWC finds that no additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the DWC finds that the requester 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 requester is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 18, 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 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.

[1] 28 TAC §134.503 (c)