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
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-20-2801-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 29, 2020

REQUESTOR'S POSITION SUMMARY

"The above claimant received medication and carrier denied the request indicating that the bill has been returned, as an alternate vendor. Memorial Compounding Pharmacy does not have a contract with the alternate vendor; therefore, claim should be processed by the direct carrier."

Amount in Dispute: $259.90

RESPONDENT'S POSITION SUMMARY

"The Carrier has paid for the medications in dispute. Please see the attached EOB which shows recommended allowance made pursuant to the fee guidelines."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2020	Omeprazole DR 20 mg Capsules	$259.90	$257.00

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:
   - HED1 – Denial – the Diagnosis Code(s) on this bill are not covered.

Issues

1. Is this dispute subject to dismissal based on relatedness to the injury?
2. Is Memorial Compounding Rx (Memorial) entitled to reimbursement?

Findings

1. Memorial is seeking reimbursement for Omeprazole DR 20 mg capsules dispensed on March 6, 2020. The insurance carrier denied the drug based on relatedness to the compensable injury. A dispute regarding relatedness must be resolved prior to a request for medical fee dispute.[1]

   The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves compensability or liability.[2] Review of the submitted documentation finds that Downs-Stanford, P.C. failed to attach a copy of a related PLN on behalf of the insurance carrier to support a denial based on relatedness to the compensable injury.

   This dispute is not subject to dismissal as the denial reason was not supported.

2. In its position statement, Downs-Stanford, P.C. said, "The Carrier has paid for the medications in dispute." The DWC reviewed the submitted documents.

   The insurance carrier submitted a document dated July 24, 2020, as evidence of payment. This document indicates that the review agent recommended no payment for the drug reviewed in this dispute. Based on the documentation provided, the DWC finds that there is insufficient evidence that the insurance carrier reimbursed the drugs in question.

   Because the insurance carrier failed to support payment of the drug in question, Memorial is entitled to reimbursement.

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

   - Omeprazole DR 20 mg capsules: (3.37338 x 60 x 1.25) + $4.00 = $257.00

   The total allowable reimbursement is $257.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 $257.00.

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 $257.00, 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	May 21, 2021 Date

[1] 28 TAC §§133.305(b) and 133.307(c)(1)(B)(i)
[2] 28 TAC §133.307 (d)(2)(H)
[3] 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.