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
M4-20-2804-01

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. This claim has been denied incorrectly."

Amount in Dispute: $507.52

RESPONDENT'S POSITION SUMMARY

"The medication, Meloxicam, was paid pursuant to the fee guidelines. The medication, Omeprazole, was denied as the medication was for diagnoses not related to the compensable injury, but instead related to disputed conditions."

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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2020	Meloxicam 7.5 mg Tablets	$247.62	$0.00
April 30, 2020	Omeprazole DR 20 mg Capsules	$259.90	$0.00
	Total	$507.52	$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 §133.305 sets out the general medical dispute resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - D3 – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
   - HED1 – Denial – the Diagnosis Code(s) on this bill are not covered.

Issues

1. Is the insurance carrier's denial of payment for omeprazole based on extent of injury supported?
2. Is Memorial Compounding Rx (Memorial) entitled to reimbursement for this dispute?

Findings

1. Memorial is seeking reimbursement, in part for Omeprazole, dispensed on April 30, 2020. Per explanation of benefits dated June 30, 2020, the insurance carrier denied the drug, stating, "the Diagnosis Code(s) on this bill are not covered."

   28 Texas Administrative Code §133.305 (b) states that if a dispute over the extent of the compensable exists for the same service for which there is a medical fee dispute, that dispute shall be resolved prior to the submission of a fee dispute for the services.

   The insurance carrier denied payment to the requestor due to an unresolved extent-of-injury issue. The requestor was notified of the denial via an explanation of benefits.[1] Additionally, the insurance carrier presented a copy of a Plain Language Notice[2] for the services, as required.[3]

   The DWC concludes that an unresolved extent-of-injury issue exists for the service in dispute. Medical fee dispute resolution is not the proper venue for resolution of an extent-of-injury dispute. The correct venue for resolution of an extent-of-injury dispute is found at Texas Labor Code, Chapter 410, and corresponding 28 Texas Administrative Code §141.1.

   To initiate resolution of an extent-of-injury issue, the requestor should complete and file a DWC Form-045 *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC)*. A copy of the form and instructions are attached.

2. Memorial is also seeking additional reimbursement for Meloxicam dispensed April 30, 2020. Per explanation of benefits dated June 30, 2020, the insurance carrier reduced the billed amount to a total payment of $241.65 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.[4]

   Memorial is requesting an additional reimbursement of $247.62 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.

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[1] 28 Texas Administrative Code §133.240
[2] Plain Language Notice as defined by 28 TAC §124.2
[3] 28 Texas Administrative Code §133.307 (d)(2)(H)
[4] 28 TAC §134.503 (c)

Conclusion

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

Authorized Signature

		September 8, 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.