TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING RX

Respondent Name
FEDERATED SERVICE INSURANCE COMPANY

MFDR Tracking Number
M4-21-1469-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 22, 2021

Response Submitted by:
No Response Submitted

REQUESTOR'S POSITION SUMMARY

"Memorial Compounding has provided service and met all requirements to received reimbursement."

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Federated Service Insurance Company is J.T. Parker & Associates LLC. J.T. Parker & Associates LLC., was notified of this medical fee dispute on April 28, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14-calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2020	Prescribed Medication	$560.24	$496.68

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier denied the services in dispute with denial reason codes:
   - 16 – Claims/service lacks information or has submission/billing error(s)
   - 270 – No allowance has been recommended for this procedure/service/supply. Please see special *Note. his bill has been reconsidered and no additional money is due.

- Note: Our records indicate this medication has been paid through our pharmacy benefit manager. Script Advisor, with any reimbursement to your facility coming directly from Script Advisor. Any questions, concerns, or disputes regarding the payment should be directed to Script Advisor

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the prescribed medications?

Findings

1. Memorial Compounding Pharmacy seeks reimbursement of $560.24 for medication dispensed on July 21, 2020. The insurance carrier denied the disputed medications with claim adjustment reason code 16 and 270 (description provided above).

   The division finds that the insurance carrier did not submit a response to the DWC060 and therefore, has failed to articulate any arguments to support its denial for of the medications in dispute. Therefore, the division concludes that the denial of payment is not supported. As a result, the disputed medication will be reviewed for reimbursement

2. The requestor seeks reimbursement in the amount of $560.24 for medication dispensed on July 21, 2020. The insurance company provided no evidence to support the denial reasons indicated on the EOBs. The service in dispute will be reviewed per applicable guidelines.

   Per 28 TAC §134.503 (c) states the insurance carrier shall reimburse the healthcare provider or pharmacy processing agent for prescription drugs the lesser of the fee established by the following formulas 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:

   - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   - Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount.

The DWC found no evidence that the prescribed medication in dispute is not covered under the Texas Workers' Compensation formulary. Therefore, the DWC finds that Memorial is entitled to reimbursement for this drug.

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

- Omeprazole DR 20 mg: (3.37338 x 30 x 1.25) + $4.00 = $130.50
- Celecoxib 100 mg: (4.61660 x 60 x 1.25) + $4.00 = $350.25
- Amitriptyline HCL 10 mg: (0.31800 x 30 x 1.25) + $4.00 = $15.93

The total allowable reimbursement is $496.68. Therefore, 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 $496.68.

[1] 28 TAC §133.307 (d)(2)(F)
[2] 28 TAC §134.503 (c)
[3] 28 TAC §134.503 (c)

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 $496.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 15, 2021
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.