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
Ace American Insurance Co

MFDR Tracking Number
M4-23-0826-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 8, 2022

SUMMARY of FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 10, 2022	10702-0006-10	$109.18	$68.60
October 10, 2022	00781-2868-10	$324.42	$14.80
October 10, 2022	00172-5728-60	$202.82	$185.65
	Total	$636.42	$269.05

Requestor's Position Summary

"The original claim was denied on 07/19/2022 based on no denial code). An appeal was submitted on 11/03/2022. ...In addition, the explanation of benefits states that (Duplicate Claim) is the new denial reason. There were not any additional code changes or services rendered. Therefore, the carrier cannot change from the original denial."

Amount in Dispute: $636.42

Respondent's Position

"A copy of the subsequent PLN11 disputing the extent of injury that has been filed with the DWC as well as a copy of the peer review report supporting our position that the treatment is not related to the accepted compensable injury is also attached."

Response submitted by: ESIS

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.

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.

Issues

1. Did the insurance carrier pose a new issue?

2. What rule(s) apply to disputed services?

3. Is the requestor entitled to additional benefits?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed October 10, 2022. The insurance carrier states in their position statement "… the treatment is not related to the accepted compensable injury …" DWC Rule 28 TAC §133.307 (F) states in pertinent part, the responses shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party.

   Any new denial reasons or defenses raised shall not be considered in the review.

   Review of the submitted documentation found insufficient evidence to support the insurance carrier issued an explanation of benefits denying the charges based on extent of liability,

   These medications will be reviewed per applicable fee guideline.

2. DWC Rule 28 Texas Administrative Code §134.503 (c) states the insurance carrier shall reimburse the health care 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;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	10702000610	G	1.72	30	$68.60	$109.18	$68.60
Omeprazole Dr	00781286810	G	0.14	60	$14.80	$324.42	$14.80
Famotidine	00172572860	G	2.4	60	$185.65	$202.82	$185.65
						Total	$269.05

3. The total reimbursement is $269.05. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $269.05

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $269.05, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 3, 2023
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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.