



# 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 Pharmacy

**Respondent Name**

ACE American Insurance Company

**MFDR Tracking Number**

M4-18-3193-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

May 2, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These medications due not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** \$74.56

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Our bill audit company has determined additional monies are owed."

**Response Submitted by:** Gallagher Bassett

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 17, 2017	Acetaminophen/Codeine #3 Tablets	\$74.56	\$25.33

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 197 – Precertification/authorization/notification absent.
  - P4 – Workers' Compensation claim adjudicated as non-compensable. This payer not liable for service/treatment.
  - Comments: COMPENSABILITY DENIED
  - 18 – Exact duplicate claim/service

**Issues**

Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

**Findings**

Memorial is seeking reimbursement for Acetaminophen/Codeine #3 tablets dispensed on May 17, 2017. In its position statement on behalf of ACE American Insurance Company, Gallagher Bassett did not maintain its denial of payment for the drug in question. The insurance carrier did not present evidence that reimbursement was provided to Memorial.

Therefore, the DWC finds that Memorial is entitled to reimbursement for the drug in question. The reimbursement for the drug considered in this dispute is calculated as follows<sup>1</sup>:

- Acetaminophen/Codeine #3 tablets:  $(0.28435 \times 60 \times 1.25) + \$4.00 = \$25.33$

The total reimbursement is therefore \$25.33. This amount is recommended.

**Conclusion**

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 \$25.33.

***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 \$25.33, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

	Laurie Garnes	March 22, 2019
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.**

<sup>1</sup> 28 Texas Administrative Code §134.503(c)