



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

MEDI-PLUS PHARMACY  
PO BOX 546  
BARKER TX 77413-0546

#### **Respondent Name**

LIBERTY MUTUAL FIRE INSURANCE

#### **Carrier's Austin Representative Box**

Box Number: 01

#### **MFDR Tracking Number**

M4-13-1490-01

#### **MFDR Date Received**

FEBRUARY 13, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "According to Texas Administrative Code, Rule 134.503, the fees established by the following formulas based on the average wholesale price (AWP) by utilizing a nationally recognized pharmaceutical reimbursement system (e.g. Redbook, First Data Bank Services) in effect on the day the prescription drug is dispensed."

**Amount in Dispute:** \$264.75

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Additional payment in the amount of \$1.25 is being processed for service of 8/7/2012. This brings that dates reimbursement in line with the remaining dates through 11/29/2012 as listed on the Table of Disputes Services. Reimbursement was calculated using the AWP provided through Medispan which is also consistent with the pricing through Red Book."

**Response Submitted by:** Liberty Mutual Insurance Co.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 7, 2012 September 2, 2012 September 28, 2012 October 24, 2012 November 19, 2012	METHOCARBAMOL 750MG TABLET	\$264.75	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307, effective May 25, 2008 33 Texas Register 3954 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.503, effective October 23, 2011, sets out the reimbursement for the pharmaceutical services in dispute.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 45, P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
  - W1 – Workers' Compensation State Fee Schedule Adjustment.
  - Z650 – Charge for this procedure exceeds average wholesale price plus mark-up.
  - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

### **Issues**

1. How is reimbursement established for the service(s) in dispute?
2. Did the requestor support its request for additional reimbursement?

### **Findings**

1. Reimbursement for the service in dispute may be established by applying 28 Texas Administrative Code §134.503, effective from October 23, 2011, which states, in pertinent part:
  - (a) Applicability of this section is as follows:
    - (1) This section applies to the reimbursement of prescriptions drugs and nonprescription drugs or over-the-counter medications as those terms are defined in §134.500 of this title (relating to Definitions) for outpatient use in the Texas workers' compensation system, which includes claims:
      - (A) subject to a certified workers' compensation health care network as defined in §134.500 of this title;
      - (B) not subject to a certified workers' compensation health care network; and
      - (C) Subject to Labor Code §504.053(b)(2).
    - (2) This section does not apply to parenteral drugs.
  - (b) For coding, billing, reporting, and reimbursement of prescriptions drugs and nonprescription drugs or over-the-counter medications, Texas workers' compensation system participants shall apply the provisions of Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits—Guidelines for Medical Services, Charges, and payments, respectively.
  - (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescriptions drugs the lesser of:
    - (1) The fees established by the following formulas based on the average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed.
      - (A) Generic drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee = MAR;
      - (B) Brand name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee = MAR;
      - (C) When compounding, a single compound fee of \$15 per prescription shall be added to the calculated total for either paragraph (a)(A) or (B) of this subsection; or
    - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
      - (A) health care provider;

Review of the explanation of benefits, position statements, and other documentation provided by the parties finds that: (1) no contract exists between the parties; and that (2) there are no denial codes or assertions refuting that the amount charged is the usual and customary amount. Consequently, the MAR in this medical fee dispute is established by determining the lesser of the charged amount and the AWP formula pursuant to 28 Texas Administrative Code §134.503(c)(1).

2. 28 Texas Administrative Code §134.503(c)(1) (effective October 23, 2011) states, in pertinent part, that "The fees established by the following formulas based on the average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed."

The Pharmacy Fee Guideline establishes that the Division expects AWP prices to be updated daily. Because the requestor has the burden of proof in this medical fee dispute, it must provide evidence to support that any asserted AWP values used to calculate reimbursement pursuant to §134.503(c)(1) were in effect on the day the disputed drug was dispensed. A mere assertion of the rate in effect on the day that the drug is dispensed is not sufficient.

3. The pharmaceutical in dispute was dispensed on January 5, 2012. After thorough review of the information and documentation provided by the parties, the Division finds:
  - The respondent did not provide any evidence to support the asserted AWP price or effective date; however additional payment in the amount of \$2.25 plus interest was made for date of service August 7, 2012.
  - In order to refute the carrier's payment in this medical fee dispute, the requestor alleged that a Rx30 Pharmacy System AWP pricing of 0.4675 per unit for METHOCARBAMOL 750MG TABLET, 120 count, NDC 00143129205, should be used as a basis for additional reimbursement. The requestor provided evidence to support the asserted RX30 Pharmacy System AWP price and effective date.

The Division's AWP database shows an AWP of 0.11748, dated August 18, 2011. The formula is as follows:  
$$0.11748 \times 120 \times 1.25 + \$4.00 = \$21.62 \times 5 \text{ dates of service} = \$108.10$$

The total MAR for the services in dispute is \$108.10. The respondent paid a total of \$108.10 for that reason, the Division concludes that the requestor has failed to prove it is entitled to additional reimbursement.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has failed to support its request for additional reimbursement. As a result, the amount ordered is zero.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §§413.031 and 413.019 (if applicable), the division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

#### **Authorized Signature**

_____	_____	February 28, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**