



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

American Specialty Pharmacy

Respondent Name

Zenith Insurance Co

MFDR Tracking Number

M4-16-0628-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

November 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$3,952.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MFDR, our Bill Review department received an email from the Examiner to process these services for payment. ..."The total amount being reimbursed to the Provider is \$291.01 based upon the TX Pharmacy fee guidelines for compound drugs."

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 25, 2014	Flurbiprofen, Ketamine, Lidocaine, Gabapentin, Nifedipine, Pentoxifylline, Alpha Lipoic Acid, Ethoxy Diglycol, Propylene Glycol, Versapro Cream	\$3,952.00	\$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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes;

- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- 350 – TX Bill has been identified as a request for reconsideration or appeal
- DP2 XX – TMESYS processes Zenith’s pharmacy bills. Please submit your bill to TMESYS using one of the methods outlined below
- 790 TX – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- 791 TX – This item is reimbursed as a brand-name prescribed drug

Issues

1. Did the requestor support its request for additional reimbursement?

Findings

1. The requestor indicated on the table of disputed services that it is seeking additional payment for pharmaceutical services. The applicable fee guideline for the disputed services is found at 28 Texas Administrative Code §134.503(c) and states, in pertinent part that:

The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) 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:

(A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;

(C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(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; or

(B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The carrier in this case made payments totaling \$291.01 for the service in dispute. The requestor in this dispute has the burden to prove why it believes that it is due additional reimbursement. Review of the documentation finds that the provider failed to submit a position explaining why it believes that additional reimbursement is due. The division further finds that the requestor failed to provide evidence that the amount it is seeking was calculated in accordance with applicable Rule §134.503(c) stated above. For those reasons, additional reimbursement cannot be recommended.

Conclusion

The division concludes that the requestor failed to demonstrate that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 13, 2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request 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 §141.1(d).

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