



**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**

Sentix Pharmacy and Discount LLC

**Respondent Name**

American Zurich Insurance Co

**MFDR Tracking Number**

M4-16-2489-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

April 18, 2016

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "As the insurance carrier took no action within the 45-day period as required by the applicable regulations, the Pharmacy now seeks payment of the claim in full.

**Amount in Dispute:** \$1,717.28

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 28, 2015	Ketoprofen 10%, Amitriptyline 2%, Baclofen 4%, Amantadine 8%, Gabapentin 5%, Versatile Base Cream	\$1,717.28	\$1,717.28

**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 §134.530 sets out the guidelines for pharmacy services not subject to a certified network.
- Neither party submitted an explanation of benefits relevant to the services in dispute.

**Issues**

1. What is the applicable rule and fee guideline that pertains to the services in dispute?
2. Based on applicable fee schedule is payment due?

**Findings**

1. 28 Texas Administrative Code §134.503(c)(1)states,

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

(B) Brand name drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  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

The total allowable reimbursement will be calculated based on the submitted NDC and reported units as follows:

Date of Service	Prescribed Medication	Units	Amount billed	MAR (AWP) x units x 1.25 + \$4.00
December 28, 2015	Ketoprofen 10%	18 bottles	\$188.10	$10.45000 \times 18 \times 1.25 + \$4.00 = \$239.13$
December 28, 2015	Amitriptyline	4 bottles	\$65.66	$\$18.24000 \times 4 \times 1.25 + \$4.00 = \$65.66$
December 28, 2015	Baclofen 4%	7 bottles	\$256.53	$\$35.63000 \times 7 \times 1.25 + \$4.00 = \$256.53$
December 28, 2015	Amantadine 8%	14 bottles	\$348.84	$\$24.22500 \times 14 \times 1.25 + \$4.00 = \$427.94$
December 28, 2015	Gabapentin 5%	9 bottles	\$538.65	$\$59.85000 \times 9 \times 1.25 + \$4.00 = \$677.31$
December 28, 2015	Versatile Base Cream	128 bottles	\$319.50	$\$2.50000 \times 128 \times 1.25 + \$4.00 = \$404.00$
			Total	\$2,070.57

2. The total allowable based on the submitted claims’ NDC numbers and units dispensed, is \$2,070.57. The requestor is seeking \$1,717.28. Pursuant to applicable fee guidelines this amount is allowed.

**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 \$1,717.28.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,717.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

May , 2016

**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, 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 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.**