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 Pharmacy

Respondent Name
Arch Insurance Company

MFDR Tracking Number
M4-18-2092-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial compounding is an approved provider and should be reimbursed accordingly."

Amount in Dispute: $618.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been disputed as the prescription was not prescribed by the treating physician."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2017	Medications	$618.92	$556.64

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 reimbursement guideline for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - Denied –Physician not authorized

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for medications dispensed on June 29, 2017 that totals $618.92.

   The insurance carrier denied disputed services as "Denied – Physician not authorized."

   Review of the injured workers TXCOMP profile finds the "Treating Doctor" to be Anibal Rossel. Review of the submitted DWC066 finds in box 13 "Rossel, Anibal" listed as the prescribing Doctor.

   The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.503 applies to the medication in dispute and states, in pertinent part:

   (c) 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 per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

   The fee calculation is found below:

Medication	NDC	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Cyclobenzaprine	65162054150	$1.092	60	$81.90	$123.02	$81.90
Duloxetine	68180029603	$7.85	30	$294.38	$293.05	$293.05
Meloxicam	29300012510	$4.845	30	$181.69	$202.85	$181.69
					Total	$556.64

The total reimbursement is therefore $556.64. 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 $556.64.

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 $556.64, 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: July 24, 2018

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.