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
New Hampshire Insurance Co

MFDR Tracking Number
M4-18-3155-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the original bill as well and the reconsideration based on duplicate."

Amount in Dispute: $129.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "First Script has already made payment on the bill provided to us..."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 26, 2017	Prescribed oral medication	$129.05	$89.40

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 of pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact Duplicate claim/service
   - 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
   - 45 – Charge exceeds the fee schedule/maximum allowable or contracted/legislated fee arrangement
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the respondent's position supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "First script has already made payment..."

   Review of the submitted documentation found the insurance carrier associated with this claimant's employer is New Hampshire Insurance Co.

   The explanation of benefits from Gallagher Bassett cited New Hampshire Insurance Co.

   Insufficient evidence was found to support a different payor or a contract exists. The services in review will be made based on applicable fee guidelines.

2. 28 TAC 134.503 (c) states, the insurance carrier shall reimburse prescription drugs the lesser of 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. Generic drugs: (AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount.

   The allowable based on the above and the submitted DWC066 is found below.

   - Naproxen AWP, $1.192 x 125% x 60 = $89.40

3. The total allowed amount is $89.40. The total billed amount was $129.05. The recommended amount (lesser of billed and allowed) is $89.40.

Conclusion

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $89.40.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
DWC hereby ORDERS the respondent to remit to the requestor $89.40, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 11, 2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

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