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
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-18-3341-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

Amount in Dispute: $782.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2017	Medication	$782.14	$705.83

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 fee guidelines for pharmacy services.
3. Neither party submitted an explanation of benefits with this dispute.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking $782.14 for medication dispensed on November 15, 2017. Neither party submitted an explanation of payment or denial. The services in dispute will be reviewed per applicable Division fee guidelines.

28 Texas Administrative Code 134.503 (c) states in pertinent part,

> 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;
>
> (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

The fee calculation based on the above is as follows:

- Tramadol, 69543-0135-11 has an allowable of $0.83 x 90 units = $93.70. The requestor billed $132.46 however based on the above $93.70 is allowed
- Gabapentin, 49483-0606-50 has an allowable of $1.33 x 60 units = $99.75. The requestor billed $137.30 however based on the above $99.75 is allowed
- Celecoxib, 60505-3849-05 has an allowable of $7.58 x 60 units = $568.60. The requestor billed $512.38. Based on the above $512.38 is allowed

The total allowed amount is $705.83. 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 $705.83.

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 $705.83, 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	September 21, 2018 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 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.