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
Zurich American Insurance Co

MFDR Tracking Number
M4-18-4271-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not required preauthorization therefore do not need a retrospective review."

Amount in Dispute: $583.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor has not shown itself entitled to payment.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 29, 2017	Compound pharmacy	$583.89	$583.89

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 §133.240 sets out guidelines for denial of medical claims.
3. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §134.530 sets out the requirements of prior authorization
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer
   - P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier

Issues

1. Is the insurance carrier's reasons for denial of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of pharmacy services rendered on November 29, 2017. The insurance carrier denied based on medical necessity and non-liability.

   28 TAC 133.230 (h) (1) (2) and (3) states an insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that the injury is not compensable, the insurance carrier is not liable for the injury due to lack of insurance coverage; or the condition for which the health care was provided was not related to the compensable injury.

   Review of the submitted documentation found insufficient evidence to support this notice (PLN11) was filed. The disputed service will be reviewed based on division fee guideline.

2. 28 TAC 134.503 (c) states the reimbursement for prescription drugs the is 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 of the providers submitted charge.

   - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   - Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

   Calculation based on the above is as follows:

Medication	NDC	Units	AWP	MAR	Billed amount
Flurbiprofen	38779036209	6	$36.58	$36.58 x 1.25 x 6 = $274.35	$219.48
Meloxicam	38779274601	0.18	$194.67	$194.67 x 1.25 x 0.18 = $43.80	$35.04
Mefenamic Acid	38779066906	1.8	$123.60	$123.60 x 1.25 x 1.8 = $278.10	$222.48
Baclofen	38779038809	3	$35.63	$35.63 x 1.25 x 3 = $133.61	$106.89
				Total	$583.89

3. The lesser or allowed amount $583.89.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $583.89.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $583.89, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 19, 2019
Signature	Medical Fee Dispute Resolution Officer	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.