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
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-19-0981-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the carrier cannot change from the original denial."

Amount in Dispute: $232.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Both medications prescribed are Y drugs. …Per office notes Cyclobenzaprine is prescribed for lumbar spine myospasms. The Lumbar is not compensable, not related."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2018	Ibuprofen 600 mg tablets, Cyclobenzaprine 5 mg tablets	$232.78	$147.00

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 guidelines for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 85 – No explanation
   - 65 – Patient is not covered

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 insurance carrier states in their position, "The Lumbar is not compensable, not related. Please see attached PLN 11."

   Review of the submitted explanation of benefits found compensability or relatedness was not raised. 28 TAC 133.307 (2) (F) states the response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Based on the above the respondent's position will not be considered in this review.

2. 28 TAC 134.503 (c) (1) (A) (B) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for 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;
   - Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

   Calculation of the fee based on the above is found below.

Medication	NDC	Units	AWP	MAR	Billed amount
Ibuprofen	55111068305	60	$0.24	$0.24 x 60 x 1.25 = $18.00	$71.92
Cyclobenzaprine	10702000610	60	$1.72	$1.72 x 60 x 1.25 = $129.00	$160.86
				Total $147.00	$232.78

3. Per the stated rule above, the lesser amount of $147.00 is recommended.

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 $147.00.

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 $147.00, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

		December 31, 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.