



# 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**

Illinois National Insurance Co

**MFDR Tracking Number**

M4-19-1378-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 8, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "...Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

**Amount in Dispute:** \$399.11

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier is still in the process of reviewing the request. We will supplement this response once a final determination is made."

**Response Submitted by:** AIG

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3, 2018	Zolpidem Tartrate, Meloxicam	\$399.11	\$355.14

#### 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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 1 – Duplicate Paid/captured claim

**Issues**

- 1. Is the insurance carrier’s denial of payment supported?
- 2. What rule is applicable to reimbursement?

**Findings**

- 1. The requestor is seeking \$399.11 for oral medications dispensed on April 3, 2018. The insurance carrier denied stating the charges were a duplicate of a paid claim.

Review of the submitted information finds insufficient evidence to support a payment was made or that the insurance carrier provided additional evidence in this dispute. The oral medications will be reviewed per applicable fee guideline.

- 2. 28 TAC 134.502 (c) (1) states,

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 is as follows:

Drug	NDC	Generic(G ) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Zolpidem Tartrate	1366800070 5	G	\$4.63	30	\$173.45	\$196.26	\$173.45
Meloxicam	2930001251 0	G	\$4.85	30	\$181.69	\$202.85	\$181.69
						Total	\$355.14

The allowed amount is \$355.14. 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 \$355.14.

**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 \$355.14, 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

July 25, 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 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.**