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
XL Specialty Insurance Co

MFDR Tracking Number
M4-19-2338-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 21, 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: $1,255.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been made."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 2018	Lyrica, Tizanidine HCL, Chlorzoxazone, Hydrocodone/APAP	$1,255.79	$0.00

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 §134.502 sets out billing guidelines for pharmacy services.
3. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. What rule is applicable to reimbursement?

Findings

1. 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 AWP for Lyrica is $8.91789 x 90 x 1.09 +$4.00 = $878.85

   The AWP for Tizanidine HCL is $1.46524 x 60 x 1.25 + $4.00 = $113.89

   The AWP for Chlorzoxazone ix $1.08340 x 60 x 1.25 + $4.00 = $85.26

   The AWP for Hydrocodone/Acetaminophen is $0.78082 x 90 x 1.25 + $4.00 = $91.84

   The total allowed amount is $1,169.84. The requestor is seeking $1,255.79. The carrier paid $1,255.79. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		February 27, 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 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.