TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Electric Insurance Co

**MFDR Tracking Number**
M4-19-2812-01

**Carrier's Austin Representative**
Box Number 17

**MFDR Date Received**
January 22, 2019

## *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 received any correspondence as per rule..."

**Amount in Dispute:** $267.50

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier has submitted the medical bill in dispute for review, and an additional payment is forthcoming."

**Response Submitted by:** Downs Stanford

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| September 30, 2018 | Prescribed oral medication | $267.50 | $262.50 |

## *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 guideline for pharmacy services.
3. Neither party submitted an explanation of benefits indicating payment or denial.

**Issues**

What rule is applicable to reimbursement?

**Findings**

The requestor is seeking reimbursement of oral medication dispensed September 30, 2018. The insurance carrier's respondent indicated in their position statement that a payment based on the fee schedule would be made. No payment has been received to date. The services in dispute will be reviewed per applicable fee guideline.

28 TAC §134.503 (c) (1) (A) states, the reimbursement for prescription drugs 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 or the provider's submitted charge.

Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount.

Calculation of the submitted charges on the DWC066 and request for MFDR is as follows:

- Lenzapatch AWP $42.00 x 1.25 x 5 = $262.50

The allowed amount is $262.50. The billed amount was $267.50. The lesser amount or $262.50 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 $262.50.

***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 $262.50, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | December 11, 2019<br>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**.