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
Starr Indemnity Liability Co

MFDR Tracking Number
M4-19-3854-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Bill for date of service 01/23/2019 indicates that it was processed and paid. It looks like the carrier processed the claim but never issued a payment to our facility."

Amount in Dispute: $107.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2019	Tramadol	$107.78	$62.85

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 guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service
   - 193 – Original payment decision is being maintained

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor is seeking reimbursement of $107.78 for oral medication dispensed January 23, 2019. The insurance carrier denied the medication as a duplicate claim. Insufficient evidence was found to support the disputed service was previously paid or denied. The service in dispute will be reviewed per applicable fee guideline.

2. 28 TAC §134.503 (c) applies to the medication and states the following,

   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;

   Calculations based on the above is shown below.

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Tramadol	68383031910	G	$0.84	60	$62.85	$107.78	$62.85
						Total	$62.85

The total reimbursement is $62.85. This amount is recommended.

Conclusion

For the reasons stated above, additional reimbursement is due. As a result, the amount ordered is $62.85.

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 $62.85, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Peggy Miller Medical Fee Dispute Resolution Officer	October 9, 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 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.