



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

ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number

M4-19-4525-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: \$122.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has not been able to locate responses to this bill. The Carrier will supplement this Response upon completion of its investigation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 10, 2019	Acetaminophen/Cod #4 Tablet MCK	\$122.63	\$85.41

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.
3. The documentation submitted to the DWC did not include explanations of benefits.

Issues

1. Did the insurance carrier submit a supplemental response upon completion of its investigation?
2. Did the insurance carrier take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement?

Findings

1. Memorial seeks reimbursement for drugs dispensed on April 10, 2019. The respondent states in pertinent part, "The Carrier has not been able to locate responses to this bill. The Carrier will supplement this Response upon completion of its investigation." As of today, no supplemental response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307.

2. Memorial is seeking reimbursement for drugs dispensed on April 10, 2019. Memorial states in pertinent part,

"The original bill was submitted to carrier on **04/22/2019 via certified mail** ... Memorial did not receive any correspondence as per rule, so we submitted a Request for Reconsideration ... The request was submitted and received by the carrier on **05/29/2019 via certified mail** still with no response."

The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.

The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question. The DWC finds that the insurance carrier failed to support its denial of payment for the disputed drugs, and as a result, Memorial is entitled to reimbursement.

3. 28 TAC 134.503 (c)(1)(A) 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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount."

The reimbursement considered in this dispute is calculated as follows:

Generic drugs: $(\text{AWP per unit}) \times (\text{number of units}) \times 1.25 + \4.00 dispensing fee per prescription = reimbursement amount.

- Acetaminophen w/ Codeine #4 10 mg tablets CIP: $1.08550 \times 60 = \$65.13 \times 1.25 = \$81.41 + \$4.00 = \85.41

The total reimbursement is therefore \$85.41. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$85.41.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$85.41 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

October 3, 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 28 TAC §133.307, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 with the DWC. **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.