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
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-5360-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 30, 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 receive any correspondence as per rule..."

Amount in Dispute: $613.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…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
May 17, 2019	Prescribed oral medication	$613.27	$560.00

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 §134.503 sets out the reimbursement guidelines for professional medical services.
3. Neither party submitted an explanation of benefits indicating payment or denial

Issues

What rule is applicable to reimbursement?

Findings

The insurance carrier's representative indicated a supplemental response would be submitted. No response or evidence of payment was submitted to date. The disputed service will be reviewed based on applicable fee guideline.

28 TAC §134.503 (c) states the reimbursement of prescription drugs 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 billed amount.

Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount. Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription reimbursement amount;

Review of the submitted DWC066 and request for MFDR found the following items in dispute;

- Tramadol 50 mg AWP $0.796 x 1.25 x 60 = $59.70
- Etodolac 600mg AWP $1.48 x 1.25 x 60 = $111.00
- Tramadol 300 mg AWP $10.14 x 1.25 x 30 = $390.00

The allowable is $560.00. The billed amount was $613.27. The lesser amount or $560.00 is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $560.00.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $560.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 11, 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.