



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

American Zurich Insurance Co

MFDR Tracking Number

M4-20-1671-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 6, 2020

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: \$281.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 14, 2019	Oral medication	\$281.69	\$208.36

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.

Issues

What rule(s) apply to disputed services?

Findings

The requestor is seeking reimbursement for oral medication dispensed November 14, 2019. The insurance carrier provided no evidence of adjudication of these services. The service in dispute will be reviewed per applicable fee guideline.

28 Texas Administrative Code §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for 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:

- Generic drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
- Brand name drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	69097084615	G	1.09	60	\$81.86	\$122.99	\$81.86
Omeprazole	62175011843	G	3.37	30	\$126.50	\$158.70	\$126.50
							\$208.36

The total reimbursement is \$208.36. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$208.36.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. DWC hereby ORDERS the respondent to remit to the requestor \$208.36, 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

May 19, 2020
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.