



# 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 Co

**MFDR Tracking Number**

M4-20-0124-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

September 16, 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 45<sup>th</sup> day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

**Amount in Dispute:** \$132.55

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "the Carrier believes this bill has been paid and is attempting to confirm payment, perhaps through the PBM. The Carrier will supplement this Response upon completion of its investigation."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 12, 2019	Oral prescribed medication	\$132.55	\$93.81

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services.

**Issues**

What rule is applicable to reimbursement?

**Findings**

The insurance carrier was to supplement their response with proof of payment but to date none received. The services in dispute will be reviewed per the workers compensation jurisdictional fee schedule.

28 TAC 134.503 (c)(1) states in pertinent part the reimbursement of 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 amount billed with a reimbursement calculation of, (AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount.

The calculation based on the above and the submitted DWCO66 is as follows;

- Ibuprofen, AWP \$.8339 x 1.25 x 90 = \$93.81.

The total allowed amount is \$93.81. The health care provider billed \$132.55. The lesser amount of \$93.81 is the allowed amount.

The insurance carrier provided no evidence of a payment. Payment of \$93.81 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 \$93.81.

***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 \$93.81, plus applicable accrued interest per 28 TAC §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 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.**