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
M4-20-0157-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 16, 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: $543.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor's boilerplate submission falsely claims it did not receive a response from the Carrier to the bill for Omeprazole, DOS 6/19/19. Attached is the EOB of 7/11/19 showing payment... The Requestor's boilerplate submission falsely claims it did not receive a response from the Carrier to its Request for Reconsideration for payment of the bill for gabapentin and acetaminophen/codeine, DOS 6/19/19. The Carrier received that Request on 8/20/19 and issued its EOB on 8/27/19."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2019	Omeprazole DR 20 mg Capsules	$315.51	$0.00
June 19, 2019	Acetaminophen/Codeine #4 Tablets	$90.61	$45.39
June 19, 2019	Gabapentin 300 mg Capsules	$137.34	$103.80
	TOTAL	$543.46	$149.19

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) §133.240 sets out the procedures for payment or denial of medical bills.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment code
   - P12 – The charge for this prescription drug is greater than the maximum reimbursement for a generic drug
   - P13 – Payment reduced/denied based on workers' compensation jurisdictional regulations or payment policies
   - D3 – Workers' compensation jurisdiction fee schedule adjustment

Issues

1. Did the insurance carrier issue payment for Omeprazole?
2. Did the insurance carrier issue payment for Gabapentin and Acetaminophen/Codeine?
3. Is the requestor entitled to reimbursement for Gabapentin and Acetaminophen/Codeine?

Findings

1. The requestor seeks reimbursement in the amount of $315.51 for Omeprazole dispensed on June 19, 2019. Review of the EOB dated July 11, 2019 supports that the insurance carrier issued a payment in the amount of $315.51 under payment ID: 14TMB247104400. As a result, the requestor is not entitled to additional reimbursement for this drug.

2. The requestor seeks reimbursement for Gabapentin and Acetaminophen/Codeine dispensed on June 19, 2019. Review of the EOB dated, August 27, 2019 supports that the insurance carrier cited the workers' compensation fee schedule as its reason for the denial. The insurance carrier indicated a paid amount of $103.80 for Gabapentin and $45.39 for Acetaminophen/Codeine for a total recommended amount of $149.19. Further review of the EOB indicated in the "Adjustment" column a $ –149.19. The DWC concludes that the requestor was not reimbursed for the drugs in dispute as indicated on the EOB. Because the insurance carrier failed to support its denial of payment for the disputed drugs, Memorial is entitled to reimbursement, pursuant to 28 TAC §134.503(c).

3. 28 TAC §134.503 (c) states in pertinent part,

   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;

   The reimbursement considered in this dispute is calculated as follows:

   - Omeprazole DR 20 mg capsules: (4.3002 x 60 x 1.25) + $4.00 = $326.52 Memorial is seeking $315.51 for this drug. The insurance carrier issued a payment in the amount of $315.51, therefore no additional reimbursement is recommended.
   - Acetaminophen/Codeine #4 tablets: (0.55186 x 60 x 1.25) + $4.00 = $45.39
   - Gabapentin 300 mg capsules: (1.3307 x 60 x 1.25) + $4.00 = $103.80

The total reimbursement is therefore $149.19. This amount is recommended.

Conclusion

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 $149.19.

ORDER

Based on the submitted information, pursuant to TLC Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $149.19, 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 25, 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, 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 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. **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.