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
Graphic Arts Mutual Insurance

MFDR Tracking Number
M4-20-0211-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 23, 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: $268.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The pharmacy billed for Meloxicam and Acetaminophen/Cod #3. This medication was paid by our pharmacy processor on September 27, 2019."

Response Submitted by: Utica National Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2018	Meloxicam 15mg tablet Acetaminophen/COD #3 tablet	$268.88	$0.00

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 pharmacy fee guidelines.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 40 – Charge exceeds fee schedule

Issues

1. Did the insurance carrier make a payment?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor was not paid for the service in dispute and sent a request for medical fee dispute on September 23, 2019. The insurance carrier responded providing evidence of payment made on October 1, 2019 in the amount of $200.35 via check number 1289587. The calculation of the applicable fee guideline is shown below.
2. 28 TAC 134.503 (c) instructs the insurance carrier shall reimburse the health care provider or pharmacy 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.

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

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

   The reimbursement for the disputed service is found below.

Medication	NDC	AWP	Units	MAR AWP x units x 125%	Billed amount	Allowed amount
Meloxicam 15 mg	29300012510	$4.845	30	$181.65	$202.85	$181.65
Acetaminophen/Cod #3	00093015010	$0.28435	30	$10.66	$66.03	$10.66

3. The maximum allowable reimbursement is $192.31. The insurance carrier pad $200.35. No additional payment is due.

Conclusion

For the reasons stated above, DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 22, 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 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.