



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

Zurich American Insurance Co

MFDR Tracking Number

M4-20-0307-01

Carrier's Austin Representative

Box Number 19

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."

Amount in Dispute: \$304.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier is investigation the status of review and payment, and will supplement this Response upon completion of its investigation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount in Dispute, Amount Due. Row 1: June 26, 2019, Prescribed oral medication, \$304.19, \$164.57

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 of pharmacy services.
3. No evidence of payment was submitted by either party.

Issues

1. Is the respondent’s position supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent indicated an investigation of the status of payment was being made. Insufficient evidence was found to support either a payment or denial. The services in dispute will be reviewed per applicable fee guideline.
2. 28 TAC 134.503 (c) states, the insurance carrier shall reimburse 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 per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount.

The allowable based on the above and the submitted DWC066 is found below.

- Cyclobenzaprine AWP \$1.091 x 125% x 30 = \$40.91
- Tramadol AWP \$0.796 x 125% x 30 = \$29.85
- Ibuprofen AWP \$0.8339 x 125% x 90 = \$93.81

3. The total allowed amount is \$164.57. The total billed amount was \$304.19. The recommended amount (lesser of billed and allowed) is \$164.57.

Conclusion

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$164.57.

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 \$164.57, 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

December 11, 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.