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
XL Specialty Insurance Co

MFDR Tracking Number
M4-20-0455-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 21, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding Pharmacy was never notified of the extent."

Amount in Dispute: $595.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…we have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 3, 2019	Celecoxib 200mg, Cyclobenzaprine 5 mg	$595.72	$544.67

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 guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 663 (no explanation given)
   - 460 (no explanation given)

Issues

1. Is the insurance carrier's reasons for denial supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for oral medications dispensed July 3, 2019. An explanation of benefits submitted with the documentation but, an explanation of the denial was not found. The respondent was to supplement their initial response but to date none has been submitted. The services in dispute will be reviewed per applicable fee guidelines.
2. 28 TAC §134.503 (c) states reimbursement for pharmacy services 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 and the provider's billed amount.
    - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
    - Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

    The AWP for Celecoxib is $7.581 x 1.25 x 60 = $568.58. The billed amount was $512.38. This amount is recommended.

    The AWP for Cyclobenzaprine is $1.722 x 1.25 x 15 = $32.29. The billed amount was $83.34. The lesser amount is the fee calculation of $32.29. This amount is recommended.
3. The total allowable for the disputed services is $544.67

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 $544.67.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $544.67, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 20, 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.