



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

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-20-0571-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 28, 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: \$116.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The payment for the medication dispensed on 6/17/19 was included in the bulk check issued to the Provider on 10/11/19."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2019	Prescribed oral medication	\$116.19	\$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 the pharmacy fee guideline.
3. The insurance carrier provided evidence of payment made October 11, 2019

Issues

- 1. Was payment made for services in dispute?

Findings

- 1. The requestor is seeking payment of pharmacy services rendered June 17, 2019 in the amount of \$116.19. 28 TAC 134.503 (c) states in pertinent part, the reimbursement for 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 provider’s bill amount. Generic drugs: ((AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount.

The allowed reimbursement based on the above is;

- Hydrocodone/APAP, AWP 0.978 x 1.25 x 60 = \$73.35

The respondent provided evidence of a payment in the amount of \$77.36 on October 11, 2019 via check 0002290511.

No additional amount 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 not established payment 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, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

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.