



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

Travelers Indemnity Co

MFDR Tracking Number

M4-20-1300-01

Carrier's Austin Representative

Box Number 5

MFDR Date Received

January 24, 2020

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 corresponded as per Rule..."

Amount in Dispute: \$337.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider submitted a request for reconsideration and the Carrier issued reimbursement for the medications."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 2, 2019	Meloxicam 7.5mg, Cyclobenzaprine 10 mg	\$337.87	\$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 (DWC).

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier reduced the payment based on the following adjustment remarks.
 - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for medication dispensed on October 2, 2019. The insurance carrier reduced the payment based on the workers compensation fee guideline. The applicable fee guideline 28 TAC §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for 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)

Drug	NDC	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Meloxicam	29300012410	\$3.17	60	$\$3.17 \times 1.25 \times 60 =$ \$237.75	\$247.62	\$237.75
Cyclobenzaprine	69097084615	\$1.09	30	$\$1.09 \times 1.25 \times 30 =$ \$40.88	\$90.25	\$40.88
					Total	\$278.63

The total allowable is \$278.63. The insurance carrier provided evidence of payment in the amount of \$286.59. No additional payment 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

February 19, 2020

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 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 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.