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
American Zurich Insurance Co

MFDR Tracking Number
M4-20-1343-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 28, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was paid on 12/18/2019. On 12/18/2019, document control number 0002310930 on the explanation of benefits states that the payment has now been reversed."

Amount in Dispute: $509.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill was paid about 40 days prior to Memorial's request for dispute resolution. Paid in check #2310930."

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2019	Oral medication	$509.96	$509.95

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 fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D3 (P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug

Issues

Did the insurance carrier support payment per applicable fee guideline?

Findings

The requestor is seeking reimbursement of oral medication dispensed September 24, 2019. In its position statement, Flahive, Ogden & Latson argued on behalf of the insurance carrier that the bill was paid. The DWC reviewed the submitted documents.

The insurance carrier submitted a document dated December 6, 2019, as evidence of payment. This document indicates that the review agent recommended payment of $509.96 and then reversed that payment in the same document. No codes were provided to support a denial of payment for the medication in dispute.

Based on the documentation provided, the DWC finds that there is insufficient evidence that the insurance carrier reimbursed the drugs in question or provided a reason for denial as required by 28 TAC §133.240(f).

Because the insurance carrier failed to sufficiently support a denial of reimbursement or that the bill was paid, Memorial is entitled to reimbursement.

The applicable fee guideline is 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) + $4.00 dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Duloxetine	51991074810	G	7.54	60	$565.58	$509.96	$509.96

The total allowable is $509.96. The insurance carrier provided evidence of payment in the amount of $.01. Payment in the amount of $509.95 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 established payment is due. As a result, the amount ordered is $509.95.

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 $509.95, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 18, 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 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.