TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Indemnity Insurance Co of North

**MFDR Tracking Number**
M4-20-1621-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
February 27, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier denied the reconsideration based on duplicate. The above claimant received medication as prescribed by referral provider. Bill for date of service 12/10/2019 indicates that it was processed and paid. It looks like the carrier processed the claim but never issued a payment to our facility."

**Amount in Dispute:** $306.17

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** None submitted.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| December 10, 2019 | Oral Medication | $306.17 | $167.09 |

## *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:
   - 148 – This procedure on the date was previously reviewed
   - 18 – Duplicate claim/service

**Issues**

What rule(s) apply to disputed services?

**Findings**

The requestor is seeking reimbursement for oral medication dispensed December 10, 2019. The insurance carrier did not submit evidence of adjudication. The service in dispute will be reviewed per applicable fee guideline.

28 Texas Administrative Code §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 |
|---|---|---|---|---|---|---|---|
| Tramadol | 57664037718 | G | 0.796 | 15 | $14.93 | $69.44 | $14.93 |
| Omeprazole | 62175011843 | G | 3.37 | 30 | $126.50 | $158.70 | $126.50 |
| Ibuprofen | 67877031905 | G | 0.34 | 60 | $25.66 | $78.00 | $25.66 |
| | | | | | | | $167.09 |

The total reimbursement is $167.09. This amount is recommended.

**Conclusion**

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $167.09.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $167.09, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | May 18, 2020<br>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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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**.