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 RX

**Respondent Name**
ACE AMERICAN INSURANCE CO

**MFDR Tracking Number**
M4-20-2115-01

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

**MFDR Date Received**
April 30, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This claim should be processed with the full amount billed…"

**Amount in Dispute:** $58.66

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0.35. Brand name was replaced with generic equivalent based on Fee Schedule guidelines."

**Response Submitted by:** ESIS

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 24, 2020 | Pharbetol 500 mg caplets | $58.66 | $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 out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 173 – The billed amount for drug or supply exceeds reasonableness/fee schedule allowance.
   - 387 – Brand name drug replaced with generic equivalent based on fee schedule guidelines.
   - 388 – The NDC code billed is for an Over the Counter (OTC) drug and as such does not warrant a dispensing fee.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

**Issues**

Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

**Findings**

Memorial is seeking additional reimbursement for Pharbetol 500 mg caplets dispensed on January 24, 2020. The carrier reduced the billed amount to a total payment of $0.35 citing the workers' compensation fee schedule as its reason for the reduction.

The NDC number used in this bill is for a brand name drug. The insurance carrier is required to pay the cost difference between the fee established for the generic drug and the fee established for the brand name drug when the brand name is not required.[1]

Memorial is requesting an additional reimbursement of $58.66 for the disputed drug. Memorial has the burden to support its request for this amount. Memorial did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503 in its position statement.

After notification by the DWC's medical fee dispute resolution program of the insurance carrier's response and payment, Memorial did not take the opportunity to refute the carrier's payment calculation. The DWC finds that no additional reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | May 14, 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 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**.

[1] 28 TAC §134.503 (g)(2)