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
XL Specialty Insurance Co

MFDR Tracking Number
M4-21-0402-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received
November 9, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pharmacy does not need diagnosis code as we have NDC code listed on the bill."

Amount in Dispute: $497.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for XL Specialty Insurance Co is Flahive Ogden & Latson who was notified of this medical fee dispute on November 17, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 18, 2020	Oral medication	$497.65	$334.56

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 §133.10 sets out the requirements for claim submission of pharmacy claims.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

Issues

1. Is the insurance carrier's denial supported?
2. What rule applies to reimbursement of the disputed service?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in August 2020. The insurance carrier rejected the claim for the disputed services due to lack of diagnosis.

   28 TAC 133.10 (3) details the required elements of a complete pharmacy claim. Diagnosis is not listed as a required element. The service in dispute will be reviewed per applicable fee guideline.

2. 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
Meloxicam	29300012410	G	3.168	30	$118.83	$152.56	$118.83
Tramadol	57664037718	G	0.796	60	$59.71	$105.27	$59.71
Cyclobenzaprine	52817033050	G	1.64	30	$61.52	$106.72	$61.52
Gabapentin	71093011105	G	2.52	30	$94.50	$133.10	$94.50

The total reimbursement is $334.56. 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 $334.56.

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 $334.56, 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	March 11, 2021 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.