



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

New Hampshire Insurance Co

MFDR Tracking Number

M4-21-0495-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 23, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the explanation of benefits it indicates that carrier paid \$103.80 and not the full amount of \$644.86. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503(c)."

Amount in Dispute: \$507.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company stands on their original review. >>The provider is not due an additional monies as the bills were processed per the fee schedule."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 10, 2020	Oral medication	\$507.52	\$490.65

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.

Issues

What rule(s) apply to disputed services?

Findings

The requestor is seeking reimbursement for oral medication dispensed September 10, 2020. The insurance company made a statement in their response indicating payment was made per fee guideline. Insufficient evidence was found to support their statement on the two medications in dispute. 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
Meloxicam	29300012410	G	3.168	60	\$237.65	\$247.62	\$237.65
Omeprazole	62175011843	G	3.37	60	\$253.00	\$259.90	\$253.00

The total reimbursement is \$490.65. 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 490.65.

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 \$490.65, 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

December 15, 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 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.