



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

Service Lloyds Insurance Co

MFDR Tracking Number

M4-21-0896-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

February 1, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the explanation of benefits, it indicates that carrier paid \$69.83 and not the full amount of \$164.96. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503(c)."

Amount in Dispute: \$164.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Service Lloyds Insurance Co is JT Parker & Associates who was notified of this medical fee dispute on February 9, 2021. 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
November 11, 2020	Oral medication	\$164.46	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - G01 – This item is reimbursed as a generic prescribed drug

- 91 – Dispensing fee adjustment
- 350 – Bill has been identified as a request for reconsideration or appeal

Issues

What rule(s) apply to disputed services?

Findings

The requestor is seeking reimbursement for oral medication dispensed November 11, 2020. The insurance company provided evidence of a payment of \$68.93 made on January 7, 2021. The requestor believes this payment was not per the applicable fee guideline. Review per applicable fee guideline is shown below.

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;
- Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + \$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
Gabapentin	67877022305	G	1.33	30	\$49.90	\$97.42	\$49.90
Amitriptyline	16729017101	G	0.318	30	\$11.93	\$67.04	\$11.93

The total reimbursement is \$61.83. The insurance carrier paid \$68.93 no additional payment 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 not established that additional reimbursement is due. As a result, no payment is due.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 23, 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.