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
American Zurich Insurance Co

MFDR Tracking Number
M4-21-1864-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 17, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been denied incorrectly. …This is a delay in payment and should be reconsidered with interest applied."

Amount in Dispute: $582.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor claims also that it did not receive a response to the initial bill… The EOB, dated April 28, 2021, was per the attached (MCP) date stamp, received by the Requestor on May 10, 2021… …the bill is shown on the EOB to be paid at fee schedule..."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 16, 2021	Oral medication	$582.33	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - D2 (P12) – The charge for the over-the counter medication exceeds the retail price.

Issues

What rule(s) apply to disputed services?

Findings

The requestor is seeking reimbursement for oral medication dispensed April 16, 2021. The insurance company provided evidence of a $435.52 payment. The service in dispute will be reviewed per applicable fee guideline.

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;
- 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
Arthritis Pain ER	70000018002	G	0.119	90	$17.48	$68.28	$17.48
Cyclobenzaprine	52817033200	G	1.09	30	$44.93	$90.25	$44.93
Amitriptyline	00603221332	G	0.60	30	$26.62	$75.60	$26.62
Meloxicam	29300012510	G	4.845	60	$367.37	$348.20	$348.20
							$437.23

The total reimbursement is $437.23. The insurance carrier paid $435.52. The insurance carriers' explanation of benefit indicated a reduction of the 8 Hour Arthritis Pain medication allowable based on the over-the-counter medication retail price.

DWC Rule 28 TAC §134.503 (d) states reimbursement for nonprescription drugs or over-the counter medications shall be the retail price of the lowest package quantity reasonably availed that will fill the prescriptions.

Review of the submitted documentation found insufficient evidence to support the amount billed by the requestor met the requirements of the rule. 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	August 18, 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.