TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Medi-Plus Pharmacy

Respondent Name
K-Mart Corporation

MFDR Tracking Number
M4-12-3061-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medi-Plus Pharmacy, an independent pharmacy has been providing medications in accordance to 134.503."

Amount in Dispute: $467.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on June 12, 2012. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2011 – March 15, 2012	Hydrocodone/APAP 10/650 Tablets	$467.65	$467.65

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.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 3 – Charge for pharmaceuticals exceed the fees established by the fee schedule/UCR rates.
   - W1 – Workers compensation state fee schedule adjustment
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 18 – Duplicate claim/service.
   - 247 – A payment or denial has already been recommended for this service.

Issues

1. How is reimbursement established for the disputed services?
2. Did the requestor support the request for additional reimbursement?

Findings

1. The disputed fees involve pharmaceutical services subject to the fee guidelines found in 28 Texas Administrative Code §134.503, effective October 23, 2011, which states, in relevant part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) 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** [emphasis added]:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider; or
   (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

   Reimbursement for the date of service in question is the lesser of the fee established by the applicable AWP formula, or the billed amount pursuant to 28 Texas Administrative Code §134.503(c).

2. The pharmaceuticals in dispute were dispensed from October 31, 2011 through March 15, 2012. The medication in dispute is Hydrocodone/APAP 10/650 tablets, NDC 00591050305. Review of the submitted documentation finds that the requestor provided documentation sourced from First Data Bank that supports the AWP rate of 0.9092 for Hydrocodone/APAP 10/650 tablets, NDC 00591050305, effective for dates October 31, 2011 through March 15, 2012.

   The division finds that the requestor supported that the AWP rate of 0.9092 was effective for the dates of service in question. Therefore, reimbursement is calculated below:

Date Dispensed	Prescription Medication	Calculation per 134.503(c)(3)(A)	134.503 (c)(3)(B)	Lesser of 134.503 (c)(3)(A) & (B)	Carrier Paid	Balance Due
10/31/11	Hydrocodone/APAP 10/650	(0.9092 x 90 x 1.25) + $4.00 = $106.28	$106.28	$106.28	$12.75	$93.53
12/23/11	Hydrocodone/APAP 10/650	(0.9092 x 90 x 1.25) + $4.00 = $106.28	$106.28	$106.28	$12.75	$93.53

1/19/12	Hydrocodone/APAP 10/650	(0.9092 x 90 x 1.25) + $4.00 = $106.28	$106.28	$106.28	$12.75	$93.53
2/16/12	Hydrocodone/APAP 10/650	(0.9092 x 90 x 1.25) + $4.00 = $106.28	$106.28	$106.28	$12.75	$93.53
3/15/12	Hydrocodone/APAP 10/650	(0.9092 x 90 x 1.25) + $4.00 = $106.28	$106.28	$106.28	$12.75	$93.53

The total reimbursement amount for the disputed services is $531.40. The insurance carrier paid $63.75. An additional reimbursement of $467.65 is recommended.

Conclusion

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 $467.65.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $467.65, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	August 29, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.