



# 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**

Memorial Compounding Pharmacy

**Respondent Name**

Zurich American Insurance Co

**MFDR Tracking Number**

M4-18-2539-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

March 12, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier denied the reconsideration based on fee schedule."

**Amount in Dispute:** \$352.99

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "A facsimile of the original EOB is attached. It instructed the pharmacy to contact the correct payer (PBM), First Script, and provided the phone number to make that contact."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2017	Prescribed oral medication	\$352.99	\$225.38

### 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 reimbursement of pharmacy services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 23 – The impact of prior payer(s) adjudication including payments and/or adjustments
  - 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

**Issues**

1. Is the respondent’s position supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The respondent states, “Memorial should be addressing any concerns with the PBM.”

Review of the submitted documentation found the insurance carrier associated with this claimant’s employer is Zurich American Insurance Co.

The explanation of benefits from Gallagher Bassett cited Zurich American Insurance Co and the claimant’s employer. The explanation of “prior payer(s) adjudication including payments and/or adjustment.”

Insufficient evidence was found to support a different payor or that payment or denial was made. The services in review will be made based on applicable fee guidelines.

2. 28 TAC 134.503 (c) states, the insurance carrier shall reimburse 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.

The allowable based on the above and the submitted DWC066 is found below.

- Amitriptyline AWP \$1.27 x 125% x 30 = \$47.63
- Ibuprofen AWP \$0.24 x 125% x 90 = \$27.00
- Gabapentin AWP \$1.34 x 125% x 90 = \$150.75

3. The total allowed amount is \$225.38. The total billed amount was \$352.99. The recommended amount (lesser of billed and allowed) is \$225.38.

**Conclusion**

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$225.38.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services. DWC hereby ORDERS the respondent to remit to the requestor \$225.38, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

December 11, 2019  
\_\_\_\_\_  
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**