



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

Berkley Regional Ins Co

MFDR Tracking Number

M4-19-1832-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim not later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

Amount in Dispute: \$123.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier understands the bill is covered by Memorial's PBM and that it has been reviewed in accordance with Memorial's PBM contract. Memorial should contact Optum for status and resolution of any disagreement of the amount due. The Carrier will supplement this Response upon receipt of any remittance advice issued by the PBM."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2018	Cyclobenzaprine 10 mg	\$123.02	\$81.75

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. Neither party submitted an explanation of benefits related to the services in dispute.

Issues

1. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor is seeking \$123.02 for Cyclobenzaprine 10 mg dispensed July 2, 2018. The fee will be calculated per the fee guidelines outlined in 28 TAC §134.503 (c) which states, in pertinent 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:

(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;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	65162054150	G	\$1.09	60	\$81.75	\$123.02	\$81.75
						Total	\$81.75

The total reimbursement is \$81.75. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that additional reimbursement is due. The amount ordered is \$81.75.

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 \$81.75, 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

June 28, 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 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.