



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

Service Lloyds Insurance Co

MFDR Tracking Number

M4-20-0560-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

October 28, 2019

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 no 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: \$253.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are upholding the prior review that was paid at fee schedule."

Response Submitted by: Avidel

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 10, 2019, Oral prescribed medication, \$253.30, \$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 reimbursement guidelines for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- P12 - Workers' compensation jurisdictional fee schedule adjustment

Issues

What rule is applicable to reimbursement?

Findings

The insurance carrier reduced the disputed services based on the workers compensation jurisdictional fee schedule.

28 TAC 134.503 (c)(1) states in pertinent part the reimbursement of prescription drugs is 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 or the amount billed with a reimbursement calculation of, (AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount.

The calculation based on the above and the submitted DWCO66 is as follows;

- Naproxen, AWP \$1.213 x 1.25 x 60 = \$90.98.
- Cyclobenzaprine, AWP \$1.091 x 60 = \$81.83.

The total allowed amount is \$172.81. The health care provider billed \$253.30. The lesser amount of \$172.81 is the allowed amount.

The insurance carrier provided evidence of a payment made in the amount of \$180.87. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is \$0.00.

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

		December 11, 2019
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 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.