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
Safety National Casualty Corp

MFDR Tracking Number
M4-20-0672-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should be processed with the full amount bill as per Administrative Labor Code 134.503(c)."

Amount in Dispute: $220.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel respectfully requests the division issue a decision indicating that the request is entitled to $0.00 additional reimbursement for date of service 08/14/19…"

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2019	Ibuprofen 800 mg, Cyclobenzaprine 10 mg	$220.19	$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 pharmacy fee guideline.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Worker's compensation State Fee Schedule Adj

Issues

1. Is the requestor due an additional payment?

Findings

1. The requestor is seeking additional reimbursement for oral medication dispensed August 14, 2019. The insurance carrier made a payment in the amount of $139.48 on September 9, 2019 via check number 1027522.

   28 TAC 134.503 (c) state the reimbursement for pharmacy services will be 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 and the provider's billed amount.

   - 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;

   The AWP for Ibuprofen is 0.805 x 1.25 x 90 + $4.00 = $94.56 The billed amount was $129.94. The lesser amount of $94.56 is recommended.

   The AWP for cyclobenzaprine is $1.091 x 1.25 x 30 + $4.00 = $44.91. The billed amount was $90.25. The lesser amount of $44.91.

   The total allowed amount is $139.47. The insurance carrier paid $139.48. 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

Signature	Medical Fee Dispute Resolution Officer	December 20, 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.