



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

Ace American Insurance Co.

MFDR Tracking Number

M4-20-1187-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

January 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the carrier cannot change from the original denial."

Amount in Dispute: \$90.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment of \$44.94 was issued on 2-4-2020."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 20, 2019	Cyclobenzaprine 10 g	\$90.25	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 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(s) apply to disputed services?

Findings

The requestor is seeking reimbursement for oral medication dispensed August 20, 2019. The insurance carrier’s previous denial based on compensability was not upheld. The service in dispute will be reviewed per applicable fee guideline.

28 Texas Administrative Code §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for 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;
- 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	69097084615	G	\$1.09	30	$\$1.09 \times 1.25 \times 30 = \40.88	\$90.25	\$40.88

The total reimbursement is \$40.88. The insurance carrier provided evidence of a payment in the amount of 44.94. No additional payment is due.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

For the reasons stated above, DWC finds that the requestor has not established that additional reimbursement 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, DWC hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 19, 2020
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.