



**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**

Indemnity Insurance Company of North America

**MFDR Tracking Number**

M4-20-1309-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

January 24, 2020

**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 45<sup>th</sup> day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule..."

**Amount in Dispute:** \$176.04

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** None submitted.

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2019	Cyclobenzaprine, Ibuprofen	\$196.04	\$101.30

**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 (DWC).

**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 evidence of a payment or denial of the disputed services

**Issues**

What rule determines the reimbursement amount?

**Findings**

The requestor is seeking reimbursement for oral medication dispensed October 9, 2019. The respondent did not submit a position statement or evidence of payment. 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:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;
- Brand name drugs:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	69097084615	G	\$1.09	30	$\$1.09 \times 1.25 \times 30 = \$40.93$	\$90.25	\$40.93
Ibuprofen	67877032105	G	\$0.804	60	$\$0.80 \times 1.25 \times 60 = \$60.37$	\$105.79	\$60.37
						Total	\$101.30

The total reimbursement is \$101.30. This amount is recommended.

**Conclusion**

For the reasons stated above, the DWC finds that additional reimbursement is due. As a result, the amount ordered is \$101.30.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor \$101.30, 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

\_\_\_\_\_  
March 23, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 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.**