



# 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**

American Zurich Insurance Co

**MFDR Tracking Number**

M4-20-1554-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

February 20, 2020

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We received the explanation of benefits but there was no reason for reduction or denial."

**Amount in Dispute:** \$90.25

### RESPONDENT'S POSITION SUMMARY

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

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 16, 2019	Cyclobenzaprine	\$90.25	\$40.88

### 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.

**Issues**

What rule applies to disputed service?

**Findings**

The requestor is seeking reimbursement for oral medication dispensed October 16, 2019. No evidence of payment or denial was submitted. The oral medication 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:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  dispensing fee per prescription = reimbursement amount;
- Brand name drugs:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \$4.00$  dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	69097084615	G	\$1.09	30	$\$1.09 \times 125\% \times 30$ $= \$40.88$	\$90.25	\$40.88

The total reimbursement is \$40.88 this amount 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 established payment is due. As a result, the amount ordered is \$40.88.

### **ORDER**

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor \$40.88, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
April 30, 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.**