



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

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-20-2026-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

April 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above claimant received medication and the carrier still has not acknowledged receipt of service> the original bill was submitted and received to carrier on 02/03/2020."

Amount in Dispute: \$273.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute for date of service 1/27/2020 to 1/27/2020. The requestor billed \$273.95.

Texas Mutual issued payment 3/02/2020 (Attachment)

No further payment due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due \$0.00
January 27, 2020	Cyclobenzaprine Tablet	\$155.74	
January 27, 2020	Hydrocodone APAP	\$118.21	

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 fee guidelines for pharmaceutical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- CAC-18 Exact duplicate claim/service
 - 224 Duplicate charge
 - CAC-P12 Workers Compensation Jurisdictional Fee Schedule Adjustment
 - CAC-91 Dispensing Fee Adjustment
 - G01 This item is reimbursed as a generic prescribed drug
 - 517 – Reviewed pursuant to Rule 133.503 to electronic bill, Call 888-880-8562

Issues

What rule(s) apply to disputed services?

Findings

The requestor is seeking reimbursement for Cyclobenzaprine Tablet and Hydrocodone APAP. The insurance company provided evidence of \$206.68 on March 2, 2020. 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: $((\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 tablet	52817033200	G	\$1.09	90	\$122.79	\$155.74	\$122.79
Hydrocodone Apap	53746011005	G	\$0.67	90	\$75.89	\$118.21	\$75.89
						Total	\$198.68

The total reimbursement is \$198.68. The insurance carrier paid \$206.68. No additional payment is recommended.

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, the Division finds that the requestor has not established that additional reimbursement is due. As a result, no payment is due.

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

July 21, 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.