

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Memorial Compounding  
RX

**Respondent Name**

Safety National Casualty Corp

**MFDR Tracking Number**

M4-21-2128-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

July 20, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 1, 2021	Cyclobenzaprine	\$106.72	\$0.00
	<b>Total</b>	\$106.72	\$0.00

### Requestor's Position

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:** \$106.72

### Respondent's Position

The Austin carrier representative for Safety National Casualty Corp is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on July 27, 2021.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

# Findings and Decision

## Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

## Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

## Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.

## Issues

1. What rule(s) apply to disputed services?

## **Findings**

1. The requestor is seeking reimbursement for oral medication dispensed April 1, 2021. The insurance carrier provided evidence of payment in the amount of \$65.53. The 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;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	52817033050	G	1.64	30	\$65.52	\$106.72	\$65.52

The total reimbursement is \$65.52. No additional payment is recommended.

## Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been

discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is [not] entitled to additional reimbursement for the disputed services.

### Authorized Signature

_____	_____	September 24, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).