TDI Division of Workers' Compensation

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# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
City of Houston

**MFDR Tracking Number**
M4-22-2677-01

**Carrier's Austin Representative**
Box Number 29

**DWC Date Received**
February 24, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| December 8, 2021 | 52817-0332-00 | $90.25 | $0.00 |
| | **Total** | $90.25 | $0.00 |

## Requestor's Position

"The disputed pharmacy services are in regard Administrative Code 134.503(c) which require the insurance carrier shall reimburse the pharmacy for prescription drugs lesser of: The fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price or other publication of pharmaceutical pricing data in effect on the day the prescription drug was dispensed."

**Amount in Dispute:** $90.25

## Respondent's Position

"In researching the date of service, it has been found that the medical provider was issued payment on 01/10/22 via Virtual Card Draft #1021273969. Proof of payment has been supplied in this response to show that the status of this payment cleared."

**Response Submitted by:** Injury Management Organization Inc

# 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 oral medications.

Denial Reasons

- The billed amount for drug or supply exceeds Medispan allowance
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Did the respondent support disputed services were paid?

**Findings**

1. The requestor is seeking reimbursement for oral medication dispensed in December 2021. The insurance company provided evidence of payment made in the amount of $44.94 paid January 10, 222 via check number 000000000000074.

   DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

   (1) 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:

   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

   (B) 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 | 52817033200 | G | 1.09 | 30 | $44.93 | $90.25 | $44.93 |
| | | | | | | $90.25 | $44.93 |

The total reimbursement is $44.93. The insurance carrier paid $44.94. 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**

| Signature | Medical Fee Dispute Resolution Officer | January 5, 2023<br>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. 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.

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 electronico CompConnection@tdi.texas.gov.