



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Wellness Pharmacy

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-24-1647-01

Carrier's Austin Representative

Rep Box 45

DWC Date Received

April 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 28, 2023	NDC # 16571-0783-10	\$101.86	\$60.66
Total		\$101.86	\$60.66

Requestor's Position

"The carrier denied the bill based on FEE SCHEDULE... After reviewing the explanation of benefits, it indicates that carrier paid \$4.86 and not the full amount of \$106.72 for CYCLOBENZAPRINE TAB 10MG. On date of service 04/28/2023, Memorial dispensed a 30-day supply to claimant."

Amount in Dispute: \$101.86

Respondent's Position

"Upon notification of this dispute, the Office researched the medical billing received from Memorial Wellness Pharmacy which determined that additional payment will be allowed, however, our research of the AWP and the Division's payment policies of pharmaceuticals calculate an estimated additional payment of \$60.64. The Office is requesting the Division confirm the additional payment allowed for NDC code 16571-0783-10 so that the Office allows the correct reimbursement."

Response Submitted by: State Office of Risk Management

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 Texas Administrative Code \(TAC\) §133.305](#) sets out the general procedures for medical dispute resolution.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is insurance carrier's reduction reason(s) supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement in the amount of \$101.86 for medication(s) dispensed on April 28, 2023. The insurance carrier reduced the reimbursement to \$4.86 due to the reason indicated above.

Based on the documentation provided, DWC finds that the carrier did not provide an accurate reimbursement according to the pharmacy fee guidelines. The requestor is therefore entitled to additional remaining reimbursement for the medication in dispute.

2. 28 TAC §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: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00 \text{ dispensing fee per prescription} = \text{reimbursement amount}$;

Drug	NDC	Generic(G) / Brand(B)	Price / Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed Amt
Cyclobenzaprine HCL	16571078310	G	1.64	30	\$65.52	\$106.72	\$65.52
TOTAL					\$65.52	\$106.72	\$65.52

The total reimbursement is \$65.52. The carrier paid \$4.86 on May 10, 2023; therefore, the requestor is entitled to the remaining amount of \$60.66.

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 provided, it was considered.

DWC finds the requestor has established that reimbursement of \$60.66 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to an additional payment of \$60.66 for the disputed prescription. It is ordered that respondent must remit to the requestor \$60.66 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 8, 2024 Date
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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, 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 prefiera 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.