



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Wellness Pharmacy

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-24-2064-01

Carrier's Austin Representative

Rep Box 19

DWC Date Received

May 23, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 30, 2023	NDC # 69097-0524-44	\$110.12	\$69.78

Requestor's Position

"The carrier denied the reconsideration based on FEE SCHEDULE. ... The explanation of benefits shows that the carrier paid \$0.00 and not the full amount of \$110.12."

Amount in Dispute: \$110.12

Respondent's Position

The Austin carrier representative for Safety National Casualty Corp is Flahive, Ogden & Latson. Flahive, Ogden & Latson was notified of this medical fee dispute on May 29, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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 §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 denied the payment for the disputed services with the following claim adjustment codes:

- P12: D3 – Workers' compensation jurisdictional schedule adjustment.
- D3 (P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.

Issues

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

Findings

1. The requestor is seeking reimbursement in the amount of \$110.12 for medication dispensed on August 30, 2023. The insurance carrier is denying reimbursement due to charges being greater than the maximum reimbursement for a generic drug, according to the pharmacy fee schedule. The insurance carrier did not submit a response to medical fee dispute resolution to support the claim that the charge for medications is above the maximum reimbursement for a generic drug. The Division finds that the documentation contained in the dispute is insufficient to support the carrier's denial, as a result, the requestor is entitled to reimbursement.
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 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 Amt
Diclofenac Sodium	69097052444	G	0.526	100	\$69.78	\$110.12	\$69.78
TOTAL					\$69.78	\$110.12	\$69.78

The total reimbursement is \$69.78.

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 requestor has established that reimbursement of \$69.78 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$69.78 reimbursement. It is ordered that respondent must remit to the requestor \$69.78 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 30, 2024

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, 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 prefieres 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.