TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING RX

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-21-1196-01

Carrier's Austin Representative
Box 15

MFDR Date Received
MARCH 15, 2021

REQUESTOR'S POSITION SUMMARY

"The above claimant received medication and carrier denied the request indicating that the bill has been returned, as an alternate vendor. Memorial Compounding Pharmacy does not have a contract with the alternate vendor, therefore, claim should be processed by the direct carrier."

Amount in Dispute: $755.80

RESPONDENT'S POSITION SUMMARY

"All were paid pursuant to the fee guidelines except for Duloxetine HCL. This one medication was denied as it was for a diagnosis not related to the compensable injury."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2020	Prescription Medication 31722-0581-60	$267.20	$266.13
	Prescription Medication 67877-0223-05	$177.26	$0.00
	Prescription Medication 31722-0533-05	$71.98	$0.00
	Prescription Medication 00406-0484-10	$61.37	$0.00
	Prescription Medication 21922-0009-09	$115.85	$0.00
	Prescription Medication 16103-0350-08	$62.14	$0.00
Total		$755.80	$266.13

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 (DWC).

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 reimbursement for compound medications
3. Explanation of Benefits:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - HED1-Denial-the Diagnosis Code(s) on this bill are not covered.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $755.80 for prescription medication rendered to the claimant on December 16, 2020.
2. Memorial Compounding Rx (Memorial) asserts that the carrier has not paid for the service in dispute. Review of the explanations of benefits provided finds that the carrier issued a payment in the amount of $266.23 to Memorial on February 22, 2021 for all the medications except for Duloxetine HCL (31722-0581-60).

   The DWC concludes that Memorial has received payment for all of the services in dispute except for Duloxetine HCL (31722-0581-60).
3. The respondent denied payment for Duloxetine HCL based upon code "HED1" description listed above.

   28 TAC §133.307(d)(2)(H) states, "The respondent must also provide the following information and records: If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

   The carrier did not provide any evidence that it filed a Plain Language Notice describing the disputed conditions as required by §133.307(d)(2)(H). Therefore, the DWC finds the respondent's denial based upon "HED1" is not supported. The service in dispute will be reviewed per the fee guideline.

   28 Texas Administrative Code §134.503(c)(1)(A)states, "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."

Drug NDC	**Generic(G) /Brand(B)**	**Price /Unit**	**Units Billed**	**AWP Formula**	**Billed Amt**	**Lesser of AWP and Billed**
31722-0581-60	G	$6.99	30	G (x125%) 30 + $4.00 = $266.13	$267.20	$266.13

4. The submitted explanation of benefits support payment of $266.23 was issued for prescription medication: 67877-0223-05, 31722-0533-05, 00406-0484-10, 21922-0009-09, and 16103-0350-08 based upon the fee guideline.

   Memorial is requesting reimbursement in the amount of $755.80 for the disputed service. Memorial has the burden to support its request for this amount. In its original position statement, Memorial did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503(c). After notification by the DWC's medical fee dispute resolution program of the carrier's response and payment, Memorial did not take the opportunity to refute the carrier's payment calculation. For that reason, the DWC moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended for prescription medication: 67877-0223-05, 31722-0533-05, 00406-0484-10, 21922-0009-09, and 16103-0350-08.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $266.13.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $266.13, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		06/16/2021
Signature	Medical Fee Dispute Resolution Officer	Date

RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 with the DWC. **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.