



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Memorial Compounding Pharmacy

**Respondent Name**

XL Specialty Insurance Co

**MFDR Tracking Number**

M4-21-1597-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

May 10, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 27, 2021	Oral medication	\$106.72	\$0.00
January 27, 2021	Oral medication	\$133.90	\$0.00
January 27, 2021	Oral medication	\$152.56	\$0.00
<b>Total</b>		<b>\$392.37</b>	<b>\$0.00</b>

### Requestor's Position

The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027.

**Amount in Dispute:** \$392.37

### Respondent's Position

...XL Specialty Insurance Company provides notice that the services the subject of the reimbursement request were paid on April 12, 2021 totaling \$286.83, check number 106063146.

**Response Submitted by:** Thornton Biechlin Reynolds & Guerra

## 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

Neither party submitted an explanation of benefits for the services in dispute.

### Issues

1. Did the insurance carrier support payment of the disputed services?

### **Findings**

1. The requestor is seeking reimbursement for oral medication dispensed January 27, 2021. The insurance company states in their position statement a payment in the amount of \$286.83 via check number 106063146 was made on April 12, 2021. The service in dispute will be reviewed per applicable fee guideline.

DWC Rule §134.503 (c) states the reimbursement for generic drugs is AWP per unit x number of units x 1.25 + \$4.00 dispensing fee per prescription.

<b>Drug</b>	<b>NDC</b>	<b>Generic(G) /Brand(B)</b>	<b>Price /Unit</b>	<b>Units Billed</b>	<b>AWP Formula</b>	<b>Billed Amt</b>	<b>Lesser of AWP and Billed</b>
Cyclobenzaprine	52817033050	G	1.64	30	\$65.52	\$106.72	\$65.52
Gabapentin	50228017705	G	2.519	30	\$98.48	\$133.09	\$98.48
Meloxicam	29300012401	G	3.168	30	\$122.83	\$152.56	\$122.83
						\$392.37	\$286.83

The total reimbursement is \$286.83. The insurance carrier paid \$286.83. 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 requestor 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 15, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

### Your Right to Appeal

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).