



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-21-1712-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 9, 2021	Oral medication	\$283.73	\$283.73
Total		\$283.73	\$283.73

Requestor's Position

This claim should be processed with the full amount billed as per Administrative Labor Code 134.503 (c), as well as by the direct carrier, not an alternative vendor. The carrier needs to pay for \$283.73.

Amount in Dispute: \$283.73

Respondent's Position

Due to a system/process error, the Carrier is unable to determine the status of the disputed bill/payment. The Carrier will supplement this Response upon completion of its investigation.

Response Submitted by: Flahive, Ogden & Latson

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 disputed oral medication.

Issues

1. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed February 9, 2021. The insurance carrier provided insufficient evidence to support adjudication of this medication. The medication will be reviewed per applicable fee guideline.

28 Texas Administrative Code §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: $((\text{AWP 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
Duloxetine	51991074810	G	7.54	30	\$286.79	\$283.73	\$283.73

The total reimbursement is \$283.73. This amount 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 established that additional reimbursement of \$283.73 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that New Hampshire Insurance Co must remit to Memorial Compounding Pharmacy \$283.73 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

_____	_____	September 15, 2021
Signature	Medical Fee Dispute Resolution Officer	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 electrónico CompConnection@tdi.texas.gov.