TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MEMORIAL
COMPOUNDING RX

Respondent Name
HARTFORD INSURANCE COMPANY OF

MFDR Tracking Number
M4-21-1914-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 26, 2021	Tizanidine HCL 4 MG Tablet	$145.41	$0.00
	Total	$145.41	$0.00

Requestor's Position

"The above patient was prescribed medication and the carrier received and processed the bill. Carrier denied the claim and the provider submitted a request for reconsideration. The request for reconsideration in accordance with Rule 133.250 was submitted to the carrier but claim was processed and denied again. The insurance carrier is required to take final action on the claim that references the original denial. The claim was denied for (CLAIM NOT PROCESSED)."

Amount in Dispute: $145.41

Respondent's Position

"Please accept the letter as a response to the above dispute. The original bill was processed and denied per Express Scripts in error. The bill was reprocessed and paid per fee on 7/13/21."

Response Submitted by: The Hartford

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 Texas Administrative Code §134.503 sets out the reimbursement for compound medications.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 85 – Claim not processed
- 71 – Prescriber is not covered
- Workers Compensation jurisdictional fee schedule adjustment
- Precertification/authorization/notification absent

Issues

1. Is Requestor entitled to additional reimbursement?

Findings

1. Memorial is seeking additional reimbursement for Tizanidine HCL dispensed April 26, 2021. Review of the documentation provided indicates a payment made in the amount of $113.88.

   The insurance carrier is required to pay the lesser of the DWC's pharmacy formulary 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, or the billed amount.

   Memorial is requesting an additional reimbursement of $145.41 for the disputed drug. Memorial has the burden to support its request for this amount. 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) in its position statement.

   After notification by the DWC's medical fee dispute resolution program of the insurance carrier's response and payment, Memorial did not take the opportunity to refute the carrier's payment calculation. The DWC finds that no additional reimbursement can be 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 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

[redacted]	[redacted]	September 30, 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 electronico CompConnection@tdi.texas.gov.