



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

MEMORIAL  
COMPOUNDING RX

**Respondent Name**

ACE AMERICAN INSURANCE CO

**MFDR Tracking Number**

M4-21-1975-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

July 12, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 07, 2021	Hydrocodone – APAP 325 MG	\$97.98	\$0.00
	Cyclobenzaprine 5 MG Tablet	\$155.93	
<b>Total</b>		\$253.91	\$0.00

### Requestor's Position

"The above claimant received Medication as prescribed by referral provider. Bill for date of service 04/07/2021 still has not been processed by carrier. All bills are required to be process within 45 days of receipts by the carrier as per Texas Labor Code 408.27(b). Memorial Compounding Pharmacy has not received any correspondence with explanation of review or benefits."

**Amount in Dispute:** \$253.91

### Respondent's Position

"In follow-up to the Carrier's original response filed, enclosed please find the EOB and payment information. Per the EOB, \$181.63 was recommended, and the payment was issued on 8/2/2021."

## **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:

- 4282 – Drugs identified with a Status of “Y” in the current edition of the Official Disability Guidelines treatment in Workers Comp ODG/Appendix A, ODG Workers' Compensation Drug Formulary identify a drug that can dispensed without preauthorization. The allowance has been determined in according to pharmacy fee guidelines.
- 5249 – Denied – treatment no authorized
- 197 – Payment denied/reduced for absence precertification/authorization
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment

### Issues

1. Is [Requestor] entitled to additional reimbursement?

### Findings

1. Memorial is seeking additional reimbursement for Hydrocodone APAP and Cyclobenzaprine HCL dispensed April 07, 2021. Review of the documentation provided indicates a payment made in the amount of \$181.63.

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 \$253.91 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**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

September 30, 2021  
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](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).