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
EMPLOYERS INSURANCE CO OF WAUS

MFDR Tracking Number
M4-21-2226-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
August 04, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2021	Methylprednisolone 4 MG	$87.52	$0.00
	Total	$87.52	$0.00

Requestor's Position

"Memorial Compounding Pharmacy has not received any correspondence with explanation of review or benefits."

Amount in Dispute: $87.52

Respondent's Position

"We have reviewed your dispute and found that the bill was received on 06/01/2021 and payment issued on 06/21/2021 on the 20th day from being received. The payment was issued on 06/21/2021 in the amount of $41.52 under check #0032915194 which has a total payment of $247.74. I have attached copy of EOBs and cashed check status for your review."

Response Submitted by: Liberty Mutual Insurance

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 the Pharmacy fee Guidelines
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Is [Requestor] entitled to additional reimbursement?

Findings

1. Memorial is seeking additional reimbursement for Methylprednisolone dispensed May 24, 2021. Review of the documentation provided indicates a payment made in the amount of $247.74.

   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 $87.52 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]	S[redacted]	October 12, 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.