TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-21-2470-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 26, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2021	67877-0223-05	$97.42	$53.90
June 14, 2021	29300-0168-01	$94.16	$0.00
June 14, 2021	62332-0142-71	$273.32	$273.32
June 14, 2021	00904-5769-60	$60.65	$7.94
	Total	$525.55	$335.16

Requestor's Position

Memorial Compounding has provided service and met all requirements to receive reimbursement.

Amount in Dispute: $525.55

Respondent's Position

Carrier has reprocessed this dispute based on additional information provided in Memorial Compounding's Medical Fee Dispute Resolution Request (DWC-60). Carrier will supplement the response pending conclusion of re-processing.

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

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 oral medications.

3. 28 TAC §134.530 sets of the requirements of prior authorization.

Denial Reasons

The insurance carrier denied with the following explanation codes.

- HE83 – Duplicate Paid/Captured Claim

Issues

1. What rule(s) apply to disputed services?
2. Did the requestor support required prior authorization obtained?
3. Is the requestor entitled to payment?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in June 2021. Insufficient evidence provided evidence to support payment of the dispute services. The service in dispute will be reviewed per applicable fee guideline.

   DWC Rule 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: ((AWP per unit) x (number of units) x 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
Gabapentin	67877022305	G	1.33	30	$53.90	$97.42	$53.90
Celecoxib	62332014271	G	7.19	30	$273.77	$273.32	$273.32
MAPAP Arthritis	00904576960	G	0.07	45	$7.94	$60.65	$7.94
						$431.39	$335.16

2. The health care provider submitted a medical claim for the medication Tizanidine. DWC Rule §134.530 states in pertinent part prior authorization is required for drugs identified with a status of "N" in Appendix A, ODG Workers' Compensation Drug Formulary.

   Review of Appendix A for date of service in dispute found the following.

Drug Class	Generic Name	Brand Name	Gener Equiv	**Status**
Muscle relaxants	Tizanidine	Zanaflex ®	Yes	**N**

   Review of the submitted documentation found insufficient evidence to support the health care provider obtained the required prior authorization. No reimbursement can be recommended.

3. The total reimbursement is $335.16. 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 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. It is ordered that Hartford Casualty Insurance Co must remit to Memorial Compounding RX $335.16 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 4, 2022 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.