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
Technology Insurance Company Inc

MFDR Tracking Number
M4-22-0047-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 13, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 17, 2021	52817-0332-00	$90.25	$44.93
May 17, 2021	53746-0110-05	$84.48	$0.00
	Total	$174.73	$44.93

Requestor's Position

"The above claimant received medication and carrier denied the request indicating that the bill has been returned, as an alternate vendor. Memorial Compounding Pharmacy does not have a contract with the alternate vendor; therefore, claim should be processed by the direct carrier."

Amount in Dispute: $174.73

Respondent's Position

"The Carrier submitted the bill in dispute for review, an additional payment is currently being ade pursuant to the attached EOB.

Response Submitted by: Downs Stanford

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 §134.530 sets out the fee guidelines for oral medications.

Denial Reasons

The insurance carrier reduced the payment based on the following claim adjustment codes;

- D3 P12 – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug
- W3 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

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

Findings

The requestor is seeking reimbursement for oral medication dispensed on May 17, 2021. The insurance company provided evidence of $37.73 paid in September 2121 via Payment ID: 14TMB334743101 for the Hydrocodone/Acetaminophen but the other medication in dispute Cyclobenzaprine indicates "0.00" paid. The service in dispute will be reviewed per applicable fee guideline.

DWC Rule 28 Texas Administrative Co in September 2021 via Payment ID: de §134.503 (c)(1)(A)(B) states in pertinent part (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) 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:

(A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $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
Cyclobenzaprine	52817033200	G	1.09	30	$44.93	$90.25	$44.93
Hydrocodone-Apap	53746011005	G	0.67	40	$37.73	$84.48	$37.73
						$174.73	$82.66

The total reimbursement is $82.66. The insurance carrier paid $37.73. The balance of $44.93 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 entitled to additional reimbursement for the disputed services. It is ordered that Technology Insurance Company must remit to requestor Memorial Compound Pharmacy $44.93 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 11, 2022
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.