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
Old Republic Insurance Co

MFDR Tracking Number
M4-22-0116-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
September 21, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 18, 2021	52817-0330-50	$106.72	$65.52
June 18, 2021	31722-0581-60	$267.20	$266.13
June 18, 2021	67877-0223-05	$97.42	$53.90
June 18, 2021	67877-0320-05	$88.42	$42.65
June 18, 2021	21922-0009-09	$115.85	$0.00
	Total	$675.81	$428.20

Requestor's Position

The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027.

Amount in Dispute: $675.81

Respondent's Position

Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for bill review audit and payment.

Response Submitted by: Gallagher Bassett

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 out the requirements for prior authorization.

Denial Reasons

The explanation of benefits did not include the page with the explanation of the denial.

Issues

1. Did the requestor support prior authorization requirements met?
2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement of the medication Diclofenac Sodium. DWC Rule §134.530 (b)(1)(A) states in pertinent part preauthorization is required for drugs identified with a status of "N" in the current edition of Appendix A, ODG Workers' Compensation ODG Workers' Compensation Drug Formulary. Review of Appendix A for the applicable date of service found.

Drug Class	Generic Name	Brand Name	Gener Equiv	Status
NSAIDs	Diclofenac sodium	Dyloject	No	N
NSAIDs	Diclofenac sodium	Voltaren ®	Yes	Y

   The requestor did not support which medication was dispensed. No payment is recommended for Diclofenac Sodium. The remaining medications in dispute will be reviewed per applicable fee guideline.

2. The requestor is seeking reimbursement for oral medication dispensed in June 2021. The insurance company provided insufficient evidence to support adjudication of the disputed service. 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
Cyclobenzaprine	52817-0330-50	G	1.64	30	$65.52	$106.72	$65.52
Duloxetine	31722-0581-60	G	6.99	30	$266.13	$267.20	$266.13
Gabapentin	67877-0223-05	G	1.33	30	$53.90	$97.42	$53.90
Ibuprofen	67877-0320-05	G	0.51	60	$42.65	$88.42	$42.65
							$428.20

The total reimbursement is $428.20 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 entitled to additional reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to Memorial Compounding RX $428.20 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	December 9, 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. 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.