



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Memorial Compounding  
RX

**Respondent Name**

Accident Fund Insurance Co of America

**MFDR Tracking Number**

M4-22-0209-01

**Carrier's Austin Representative**

Box Number 6

**DWC Date Received**

October 1, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 30, 2021	Oral medication	\$267.20	\$266.13
July 30, 2021	Oral medication	\$72.00	\$22.12
<b>Total</b>		\$339.20	\$288.25

### Requestor's Position

Claim still open per adjustor Tina Brittain, so this bill should be paid.

**Amount in Dispute:** \$339.20

### Respondent's Position

After review of the Provider's request, Accident Fund has determined that its denial of payment was proper and requests that the agency affirm the denial.

**Response Submitted by:** Stone Loughlin Swanson

# 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 requirements of prior authorization of pharmacy services.
3. 28 TAC §134.503 sets out the fee guidelines of pharmacy services.

## Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 71 – Prescriber is not covered
- 85 – Claim not processed
- 70 – Drug not on formulary
- 75 – Prior authorization required

## Issues

1. Is the insurance carrier's denial supported?
2. What rule(s) apply to disputed services?

## Findings

1. The requestor is seeking reimbursement for oral medication dispensed in July 2021. The insurance carrier denied the medications for prescriber not covered and drug not on formulary. Insufficient evidence was found to support these denials. The insurance carrier also denied for lack of prior authorization.

DWC Rule 28 TAC §134.530 states in pertinent part that preauthorization is only required for drugs identified with a status of "N" of Appendix A of the ODG Workers' Compensation Drug Formulary. Review of the applicable Appendix A found neither medication is listed as a "N" drug. The insurance carrier's denial is not supported. These medications will be reviewed per applicable fee guideline.

2. DWC Rule 28 TAC §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:  $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  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
Duloxetine	31722058160	G	6.99	30	\$266.13	\$267.20	\$266.13
Acetaminophen/Cod	00406048410	G	0.483	30	\$22.12	\$72.00	\$22.12

The total reimbursement is \$288.25. 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 of \$288.25 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 Accident Fund Insurance Co of America must remit to Memorial Compounding RX \$288.25 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	October 22, 2021 Date
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## **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).