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 Pharmacy

Respondent Name
Harris Health System

MFDR Tracking Number
M4-22-0787-01

Carrier's Austin Representative
Box Number 21

DWC Date Received
December 30, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 28, 2021	50228-0177-05	$284.26	$0.00
September 28, 2021	00406-0484-10	$101.00	$0.00
September 28, 2021	67877-0320-05	$103.88	$0.00
		$489.14	$0.00

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: $489.14

Respondent's Position

Respondent paid $404.62 (see attached pay summary as Exhibit A), for the following reasons: the reimbursement is based on the contracted amount and the charge billed exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Response submitted by: Thornton Biechlin Reynolds & Guerra

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.

Denial Reasons

- 877 – Reimbursement is based on the contracted amount
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

Issues

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed September 28, 2021. The insurance company provided evidence of $404.62 on October 25, 2021, via electronic funds transfer number 36197. The service in dispute will be reviewed per applicable fee guideline.

   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;
   - 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
Acetaminophen/ Cod #3	00406-0484-10	G	0.48	90	$58.37	$101.00	$58.37
Ibuprofen	67877-0320-05	G	0.515	90	$61.97	$103.88	$61.97
Gabapentin	50228-0177-05	G	2.51	90	$287.44	$284.26	$284.26
						Total	$404.60

The total reimbursement is $404.60. The insurance carrier paid $404.62. No additional payment 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 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

		March 15, 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.