



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

Technology Insurance Company Inc

MFDR Tracking Number

M4-22-0955-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

January 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2021	31722-0581-60	\$267.20	\$266.13
November 18, 2021	52817-0332-00	\$90.25	\$-0.01
		\$357.45	\$266.12

Requestor's Position

"After reviewing the explanation of benefits it indicates that alternate vendor, TMESYS paid \$185.89 and not the full amount of \$563.30. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503 (c) as well as by the direct carrier, not an alternate vendor. The carrier needs to pay \$357.45."

Amount in Dispute: \$357.45

Respondent's Position

"The Carrier submitted the bill in dispute for review, and an additional payment is currently being made."

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 §134.503 sets out the requirements of prior authorization.

Denial Reasons

- P12 – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug

Issues

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in November 2021. The insurance company provided evidence of payment in the amount of \$44.94 on February 11, 2022, for the medication Cyclobenzaprine. However, the medication Duloxetine had no explanation as to the "0.00" amount paid. The service in dispute will be reviewed per applicable fee guideline.

DWC Rule 28 Texas Administrative Code §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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 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
Duloxetine	31722058160	G	6.99	30	\$266.13	\$267.20	\$266.13
Cyclobenzaprine	52817033200	G	1.09	30	\$44.93	\$90.25	\$44.93
						\$357.45	\$311.06

The total reimbursement is \$311.06. The insurance carrier paid \$44.94. The balance of \$266.12 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 Memorial Compound RX \$266.12 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 electrónico CompConnection@tdi.texas.gov.