



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

Hartford Casualty Insurance Co

MFDR Tracking Number

M4-22-0957-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

January 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2021	52817-0330-50	\$155.93	\$127.04
		\$155.93	\$127.04

Requestor's Position

This claim should be processed with the full amount billed as per Administrative Labor Code 134.503 (c).

Amount in Dispute: \$155.93

Respondent's Position

The Austin carrier representative for Hartford Casualty Ins Co. is Burns Anderson Jury & Brenner. The representative was notified of this medical fee dispute on January 25, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 pharmacy services.

Denial Reasons

- N3 – A reduction was made because a different provider has billed for the exact services on a previous bill
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

Issues

1. Did the insurance carrier support previous payment?
2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in September 2021. The insurance company provided insufficient evidence to support the services were previously paid. The service in dispute will be reviewed per applicable fee guideline.
2. 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: $((\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
Cyclobenzaprine	52817033050	G	\$1.64	60	\$127.04	\$155.93	\$127.04

The total reimbursement is \$127.04. 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 respondent must remit to requestor \$127.04 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	<u>Peggy Miller</u>	<u>April 14, 2022</u>
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.