

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

MEMORIAL  
COMPOUNDING RX

**Respondent Name**

XL INSURANCE AMERICA INC

**MFDR Tracking Number**

M4-22-1411-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

March 10, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 11, 2022	Acetaminophen/Codeine tablet	\$77.80	\$25.37

### Requestor's Position

The above claimant received medication as prescribed by referral provider. Bill for date of service 01/11/2022 was denied indicating lack of preauthorization. These medications do not require preauthorization therefore do not need retrospective review.

**Amount in Dispute:** \$77.80

### 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 manual review to determine if additional monies are owed.

**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 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the pharmacy fee guideline.

### Denial Reasons

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

- 90438 – Payment denied/reduced for absence of precertification/authorization
- 197 – Payment denied/reduced for absence of precertification/authorization
- 5725 – First script has denied the line for utilization: for questions please call 1-888-232-0958

### Issues

1. Is MEMORIAL COMPOUNDING RX entitled to reimbursement?

### Findings

1. MEMORIAL COMPOUNDING RX is requesting reimbursement for Acetaminophen/Codeine #3 tablet dispensed on January 11, 2022.

DWC Rule 28 Texas Administrative Code §134.503(c)(1)(A)states

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;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Acetaminophen/Codeine	0040604810	G	\$0.48	42	\$25.37	\$77.80	\$25.37

Total	\$25.37
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The total reimbursement is \$25.37. 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 \$25.37 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 XL INSURANCE AMERICA INC must remit to MEMORIAL COMPOUNDING RX \$25.37 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

June 21, 2022

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](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).