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
Liberty Mutual Fire Insurance Co

MFDR Tracking Number
M4-22-1681-01

Carrier's Austin Representative
Box Number 1

DWC Date Received
April 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 19, 2022	68462-0190-05	$93.28	$0.00
January 19, 2022	70000-0058-01	$65.49	$0.00
	Total	$158.77	$0.00

Requestor's Position

"In November 2013 the Texas Department of Insurance, Division of Workers Compensation began posting the Official Disability Guidelines-Treatment in workers comp Appendix A. Drugs with a "N" status are recommended for preauthorization as indicated in the TDI-DCW's pharmacy closed formulary. All other FDA approved drugs are available for use without preauthorization. Appendix A list both Y and N status drugs. ...The service billed has a Y code therefore does not require preauthorization."

Amount in Dispute: $158.77

Respondent's Position

"We have reviewed your dispute and found that the payment was issued on 02/16/2022 in the amount of $58.74 under check #0033193850..."

Response Submitted by: Liberty Mutual

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 fee guidelines for oral medications.

Denial Reasons

The explanation of benefits did not include the page with the explanation of the denial.

Issues

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in January 2022. The insurance company provided evidence of payment in the amount of $117.42 on March 8, 2022 via check 33193850. 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: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

   (B) 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
Naproxen	68462019005	G	1.19	30	$48.72	$93.28	$48.72
Triple Antibiotic	70000005801	G	0.285	28	$13.99	$65.49	$13.99
						$158.77	$62.71

The total reimbursement is $62.71. The insurance carrier paid $117.42. 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

		May 5, 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.