TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision
General Information

Requestor Name
MEMORIAL COMPOUNDING RX

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-22-1880-01

Carrier's Austin Representative
Box Number 47

DWC Received Date
April 29, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 24, 2022	Prescribed Medication	$437.05	$342.23
	Total	$437.05	$342.23

Requestor's Position

"The above claimant received medication and the carrier still has not acknowledged receipt of service. Reimbursement should be made to the provider if the claim has been submitted within the 95th day after the date on which the health care service was rendered. The original bill was submitted to carrier on 01/31/2022 via fax confirmation."

Amount in Dispute: $437.05

Respondent's Position

The Austin carrier representative for Hartford Casualty Insurance Company is Burns Anderson Jury Brenner. Burns Anderson Jury Brenner was notified of this medical fee dispute on May 3, 2022. Per 28 TAC §133.307(d)(1) if the division does not receive the response within 14-calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.

Denial Reasons

Neither party submitted an explanation of benefits for the services in dispute.

Issues

1. What is the insurance carrier's obligation to respond to a medical bill?
2. Did the insurance carrier timely present denial reasons to the provider before the filing of this fee dispute?
3. What is the total reimbursement for the service(s) in dispute?

Findings

1. The requestor seeks reimbursement for prescribed medication rendered on January 24, 2022. The insurance carrier did not respond to the DWC060 request. The requestor indicates that an initial and reconsideration bill was submitted to the insurance carrier for review and no response was received from the insurance carrier and therefore seeks dispute resolution from MDR.

   It is the duty of the workers' compensation insurance carrier **or an agent acting on the carrier's behalf** to pay, reduce, or deny a complete medical bill within 45 days from the date of receipt. A carrier's 45-day deadline to make or deny payment is **not extended** as a result of an audit under 28 TAC §133.230, or as a result of a pending request for additional documentation. Further, the insurance carrier **shall** notify the health care provider of its final action by issuing an explanation of benefits (EOB) and shall include on its EOB any bill reductions, denial reasons, and defenses in the form and manner required by 28 TAC §133.240.

   Under 28 TAC §133.307, the DWC only reviews those denial reasons and defenses presented by the carrier to the health care provider prior to the date the request for MFDR was filed. Any denial reasons or defenses raised by the carrier after the filing of the dispute are not considered in the review of the medical fee dispute.

2. The DWC finds that the requestor, Memorial Compounding Pharmacy, presented sufficient documentation to support that it requested payment from the Hartford Casualty Insurance Company for medications provided to a covered injured employee. The Hartford Casualty Insurance Company did not pay, reduce, or deny the complete medical bill in 45 days. Due to the Hartford Casualty Insurance Company's failure to take final action and timely issue an EOB, the provider then asked for reconsideration and requested an EOB as required. The Hartford Casualty Insurance Company did not respond to the request for reconsideration. The provider then filed for medical fee dispute resolution (MFDR).

   The DWC finds that insufficient evidence was presented by the Hartford Casualty Insurance Company or its agent to support that it responded to the complete medical bill within 45 days; nor did the Hartford Casualty Insurance Company or its agent present any evidence to support that it responded to the request for reconsideration and request for an EOB. The Hartford Casualty Insurance Company therefore failed to present any denial reasons or defenses to the provider before the filing of this medical fee dispute.

   The Hartford Casualty Insurance Company failed to present any defenses that conform with the requirements of 28 TAC §133.240 and 133.250 discussed above. Absent any evidence that the Hartford Casualty Insurance Company or an agent timely presented any defenses to the provider that conform with the requirements of Title 28, Part 2, Chapter 133, Subchapter C, the DWC finds that the medications are eligible for reimbursement.

3. Rule 28 TAC §134.503 applies to the reimbursement for medications. The medications in dispute are listed on the bill separately.

   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.

The calculation of the allowable amount is as follows:

Drug	NDC	Generic(G)/ Brand(B)	Price/ Unit	Units Billed	AWP Formula	Billed Amount	Lesser of AWP and Billed
Celecoxib 200 mg	62332014271	G	$7.19398	30	$273.77	$273.32	$273.32
Gabapentin 300 mg	67877022305	G	$1.33070	30	$53.90	$97.42	$53.90
8 hr. muscle ache pain ER 650 mg	70000030601	G	$0.09790	90	$15.01	$66.31	$15.01
				Total	$342.68	$437.05	$342.23

The total reimbursement is $342.23. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has established that additional reimbursement is due. As a result, the amount ordered is $342.23.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester $342.23 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	~_____	June 27, 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 512-804-4812.