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
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-2377-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
July 8, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 25, 2022	Prescribed Medications	$160.42	$0.00
	Total	$160.42	$0.00

Requestor's Position

"The carrier denied the reconsideration based on duplicate claim. It looks like the carrier processed the claim but never issued a payment to our facility… The carrier is required to process and issue payment accordingly. We are requesting that the carrier provide a proof of payment copy of the front and back of the check as well as the check description. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503…"

Amount in Dispute: $160.42

Respondent's Position

"ESIS Med Bill Impact's Bill Review Department reviewed the above-mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $64.78."

Response Submitted by: ESIS

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.
3. 28 TAC Chapter 1305 applicable to Health Care Certified Networks.

Denial Reasons

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

- 1 – The billed amount for drug or supply exceeds Medispan allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Neither party submitted an explanation of benefits for the disputed services.

Issues

1. Did the insurance carrier issue a partial payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for prescribed medication dispensed on April 25, 2022. The insurance carrier indicates that a payment in the amount of $64.78 was issued for medications acetaminophen/codeine and Ibuprofen 200 mg.

   Review of a payment screen and an EOB provide by the insurance carrier indicates that a payment in the amount of $22.13 was issued for acetaminophen/codeine and a payment in the amount of $42.65 was issued for Ibuprofen 200 mg under check #DA90125383. The DWC will now determine if the requestor is entitled to an additional payment for the medications in dispute.

2. The service in dispute will be reviewed per applicable fee guideline. 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: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic (G)/ Brand (B)	Price/Unit	AWP Formula	Billed Amount	Insurance Carrier Paid
ACETAMINOPHEN/COD #3 TABLET MCK	00406048410	G	$0.48331/30	$22.12	$72.00	$22.13
IBUPROFEN 600MG TABLET ASC	67877032005	G	$0.51530/60	$42.65	$88.42	$42.65

3. The DWC finds that the insurance carrier issued a payment for the MAR amount for the prescribed medications indicated above. As a result, the requestor is not entitled to additional reimbursement. Therefore, additional reimbursement is not 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 not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		July 28, 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.