



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Memorial Compounding Pharmacy

**Respondent Name**

National Union Fire Ins Co of Pittsburgh PA

**MFDR Tracking Number**

M4-23-0407-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

October 14, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2022	68382-0805-01	\$89.72	\$44.27
		\$89.72	\$44.27

### Requestor's Position

"Memorial Wellness Pharmacy is an approved provider and should be reimbursed accordingly. The referral provider has been treating the patient for the injury sustained at work."

**Amount in Dispute:** \$89.72

### Respondent's Position

"Due to a system error, the Carrier's bill vendor did not receive this bill timely. It has been placed in line for payment and will be paid per fee guidelines, plus interest. The Carrier will supplement this Response upon completion of that process."

**Response submitted by:** Flahive, Ogden & Latson

## **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 requirements of prior authorization.
3. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

### Denial Reasons

- 9D(P12) – The charge for the Closed Formulary Drug requires Prior Authorization as defined within Texas Administrative Code Chapter 134, Section 114.530 and 134.540. If prior authorization was obtained, please resubmit with a copy of the required information.
- N3(B20) - A reduction was made because a different provider has billed for the exact services on a previous bill.
- ZR(P12) – The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.

### Issues

1. Did the requestor maintain their denial?
2. What rule(s) apply to disputed services?

### **Findings**

1. The requestor is seeking reimbursement for oral medication dispensed in June 2022. The insurance company denied the claim as not prior authorized and duplicate of another supplier's medical bill. Neither of these were maintained. The respondent states in their position statement that the medical bill has been placed in line for payment. Insufficient evidence was found to support a payment was made on the disputed service. This medical bill will be reviewed per applicable fee guideline.
2. 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
Trazodone Hydrochloride	68382080501	G	\$1.07	30	\$44.27	\$89.72	\$44.27
						\$89.72	\$44.27

The total reimbursement is \$44.27. 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 \$44.27 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

\_\_\_\_\_  
March 10, 2023  
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).