



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-23-0557-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

November 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 8, 2022	31722058160	\$267.20	\$266.13
		\$267.20	\$266.13

Requestor's Position

"Memorial Wellness Pharmacy later received an Explanation of Benefits from the alternate vendor reversing this payment. However, on the explanation of benefits there was no reason for reduction of or denial."

Amount in Dispute: \$267.20

Respondent's Position

"The Carrier is issuing payment to the Provider for the date of service 8/8/2022, in the amount of \$266.13."

Response submitted by: Downs Stanford PC

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 §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

- The screen shot submitted by the requestor did not include any adjustment codes or reasons. The respondent did not submit documentation to support adjudication of the claim.

Issues

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed August 8, 2022. The insurance company provided insufficient evidence to support adjudication of the disputed service. 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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 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
Duloxetine HCL	31722058160	G	6.99	30	\$266.13	\$267.20	\$266.13
						\$267.20	\$266.13

The total reimbursement is \$266.13. The insurance carrier paid \$0.00. The balance of \$266.13 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 [not] entitled to additional reimbursement for the disputed services. It is ordered that Indemnity Insurance Co of North America must remit to Memorial Compounding RX \$266.13 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	March 30, 2023
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 electrónico CompConnection@tdi.texas.gov.