

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Compounding
Pharmacy

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-22-0113-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

September 21, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2021	00603-3887-28	\$116.19	\$77.36
June 14, 2021	68382-0050-05	\$247.62	\$0.00
Total		\$363.81	\$77.36

Requestor's Position

The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027.

Amount in Dispute: \$363.81

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on September 28, 2021.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 oral medications.

Denial Reasons

Neither party submitted an explanation of benefits for the disputed date of service.

Issues

1. Did the requestor support preauthorization of Meloxicam?
2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in June 2021. The rule applicable to the disputed services is DWC Rule 28 TAC §134.530 (b)(1)(A) which states in pertinent part preauthorization is only required for drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary*, and any updates;

Review of Appendix A found.

Drug Class	Generic Name	Brand Name	Status
NSAIDs	Meloxicam	Mobic [®]	Y
NSAIDs	Meloxicam	Vivlodex [®]	N

The submitted documentation was insufficient to support the medication dispensed was not the one that required prior authorization. Payment is not recommended. The remaining disputed service will be reviewed per applicable fee schedule.

2. 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 \text{ per unit}) \times (\text{number of units}) \times 1.25) + \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
Hydrocodone	00603388728	G	0.978	60	\$77.36	\$116.19	\$77.36

The total reimbursement is \$77.36. 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 Zurich American Insurance Co must remit to Memorial Compounding RX \$77.36 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

December 20, 2021

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.