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

General Information

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-22-1989-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 12, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 13, 2021	68382-0050-05	$247.62	$241.65
		$247.62	$241.65

Requestor's Position

"The original claim was paid on 01/20/2022 on document control number 0002483046. Then on 02/18/2022, document control number 0002488497 on the explanation of benefits states that the payment has now been reversed. There were not any additional code changes or services rendered. Therefore, the alternate vendor cannot change payment decisions. As a provider you have to be able to address the bill properly for continued care."

Amount in Dispute: $247.62

Respondent's Position

"This bill has been paid per fee guideline in check no. 2501992. See attached EOB. This dispute request should be withdrawn."

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 §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

- D3 (P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug

Issues

1. Is the respondent's position statement supported?
2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in December 2021. In its position statement, Flahive, Ogden & Latson argued on behalf of the insurance carrier that the bill was paid. The DWC reviewed the submitted documents.

   The insurance carrier submitted a document dated March 23, 2022, as evidence of payment. This document indicates that the review agent recommended payment of $241.65 and then reversed that payment in the same document. No codes were provided to support a denial of payment for the drugs in dispute.

   Based on the documentation provided, the DWC finds that there is insufficient evidence that the insurance carrier reimbursed the drugs in question or provided a reason for denial as required by 28 TAC §133.240(f).

   Because the insurance carrier failed to sufficiently support a denial of reimbursement or that the bill was paid, Memorial is entitled to reimbursement.

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
Meloxicam	68382005005	G	$3.168	60	$241.65	$247.62	$241.65

The total reimbursement is $241.65. 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 $241.65 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	August 19, 2022 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 electronico CompConnection@tdi.texas.gov.