TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
MEMORIAL COMPOUNDING RX

**Respondent Name**
TX MUNICIPAL LEAGUE

**MFDR Tracking Number**
M4-22-2058-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
May 17, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| March 23, 2022 | Prescribed medication | $86.50 | $40.25 |
| | **Total** | $86.50 | $40.25 |

## Requestor's Position

"The carrier denied the reconsideration based on unresolved issues of extent of injury. A call was placed to carrier to confirm patient demographics as well as compensability. We were not notified of any disputes or PLN11 filed. The Carrier is required to notify all providers of any issues with the claimant's compensability. 28 Texas Administrative Code 133.210{e) indicates that the insurance carrier has an obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. Memorial Compounding Pharmacy was never notified of the extent."

**Amount in Dispute:** $86.50

## Respondent's Position

"This is a network claim ("The Alliance"). This prescription was written by a physician to whom the claimant was referred by his own attorney. The prescribing physician is not a contracting doctor, nor a referral from a contracting doctor with the network. Nor has any such out-of-network referral been approved by the network."

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

# Findings and Decision

## Authority

This medical fee dispute is decided according to Texas Labor Code TLC) §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. TLC §408.021 establishes entitlement to medical benefits.
4. Texas Insurance Code §1305.101 defines the duties of networks to provide medical treatment.

## Denial Reasons

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

- 157 - PAYMENT IS ADJUSTED BECAUSE THIS SERVICE WAS NOT PRESCRIBED BY A PHYSICIAN.
- 173 - SERVICE/EQUIPMENT WAS NOT PRESCRIBED BY A PHYSICIAN.
- 179 & B7 - THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.

## Issues

1. Is the insurance carrier's denial reason supported?
2. What rules apply to the disputed service?
3. Is the requestor entitled to reimbursement?

## Findings

1. Memorial seeks reimbursement for Acetaminophen/Cod #3 dispensed on March 23, 2022. The insurance carrier states the drug was denied because it was provided outside the network. Prescription medication may not, directly or through a contract, be delivered through a workers' compensation health care network.

   Texas Insurance Code §1305.101 (c) states, "(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not, directly or through a contract, be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by Section 408.0281, Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation."

   The DWC concludes that the disputed prescription medication dispensed by the provider is not subject to the provisions of a workers' compensation health care network. Because the insurance carrier failed to support its denial of payment, Memorial is entitled to reimbursement for the medication rendered on March 23, 2022.

2. The service in dispute will be reviewed per applicable fee guideline. DWC Rule 28 TAC §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 | Lesser of AWP and Billed Amount |
|---|---|---|---|---|---|---|
| ACETAMINOPHEN/COD #3 | 00406048410 | G | $0.48331/60 | $40.25 | $86.50 | $40.25 |

3. The DWC finds that the requestor is therefore, entitled to reimbursement in the amount of $40.25. Therefore, this amount is 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 established that reimbursement is due. As a result, the amount ordered is $40.25.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester the amount of $40.25 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**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.