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 Pharmacy

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-22-2165-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 16, 2022	65162-0833-66	$112.32	$0.00
March 18, 2022	52817-0331-10	$345.93	$0.00
	Total	$458.25	$0.00

Requestor's Position

"The Texas Labor Code Section 408.027(b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule…"

Amount in Dispute: $458.25

Respondent's Position

"The Carrier paid some of the scripts on this bill, specifically the $345.93 for Cyclobenzaprine HCL. Please see the attached EOB showing payment. The Carrier is investigating the non-payment of the remainder. The Carrier will supplement this response upon completion of its investigation and review."

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 for prior authorization.

3. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

The insurance carrier denied/reduced the disputed charges with the following adjustment codes.

- HE75 – Prior Authorization required to process this bill

Issues

1. Is the insurance carrier's denial supported?

2. What rule is applicable to reimbursement?

3. Is the requestor due additional reimbursement?

Findings

1. The requestor is seeking reimbursement of medication dispensed in March 2022. The disputed medication, (Diclofenac Sodium) was denied for lack of preauthorization.

   DWC Rule 134.530 (b) (1) states in pertinent part, preauthorization is only required for drugs identified with a status "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A. Review of the applicable Appendix A found two medications with the generic name "Diclofenac Sodium" that are listed as a "N" drug. Review of the submitted documentation was insufficient to support the brand name dispensed was a brand name that does not require prior authorization. The insurance carrier's denial is supported. No payment is recommended for Diclofenac Sodium.

   The oral medication (Cyclobenzaprine HCL) was paid in the amount of $345.93. The fee calculation will be addressed below.

2. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part 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
Cyclobenzaprine	5281703310	G	$4.807	60	$364.54	$345.93	$345.93
						$345.93	$345.93

3. The total reimbursement is $345.93. The insurance carrier paid $345.93. No additional payment 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 not 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.

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.