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
M4-22-2566-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 5, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 3, 2021	62332-0141-31	$196.00	$119.42
		$196.00	$119.42

Requestor's Position

"The original claim was paid on 09/16/2021 on document control number 002459363. Then on 07/28/2022, document control number 0002515096 on the explanation of benefits states that the payment has now been reversed. There was not any additional code changes or services rendered. Therefore, the alternative vendor cannot change payment decisions. As a provider ou have to be able to address the bill properly for continued care."

Amount in Dispute: $196.00

Respondent's Position

"Due to system error, only part of the original bill was paid. The Carrier is in the process of reconsidering the bill and will pay per fee guideline. The Carrier will supplement this response upon completion of that effort."

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

- The submitted explanation of benefits do not include any reason codes to explain reversal of payment

Issues

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in August 2021. The submitted documentation includes an explanation of benefits that indicates payment then a later explanation of benefits that indicates the disputed prescription payment was reversed. No explanation of this reversal was found. The prescription 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: ((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
Celecoxib	62332014131	G	4.61	30	$119.42	$196.00	$119.42
						$196.00	$119.42

The total reimbursement is $119.42. 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 $119.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 26, 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 electronico CompConnection@tdi.texas.gov.