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 Wellness Pharmacy

Respondent Name
Sentry Insurance A Mutual Co

MFDR Tracking Number
M4-23-1692-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 15, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 30, 2022	27241-0098-09	$293.05	$0.00
December 30, 2022	00904-6773-61	$70.58	$0.00
		$363.63	$0.00

Requestor's Position

"The explanation of benefits indicates that carrier pad $89.53 and not the full amount of $489.55. This claim should be processed wit the full amount billed as per **Administrative Labor Code 134.503(c).**

Amount in Dispute: $363.63

Respondent's Position

"We are working on getting payment plus interest issued for the acetaminophen and duloxetine. I will send proof of payment once available."

Response submitted by: Sentry

Supplemental response, June 7, 2023.

"Payment for the drug charges were issued on check numbers 2563387 and 2563653. Interest of $5.73 was issued on check number 52133800."

Response submitted by: Sentry

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

- REMD – These are non-covered services because this is not deemed a medical necessity by the payer.

- VPMI – Med not related to injury.

- @F (W3) – Additional payment made on appeal/reconsideration.

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

Issues

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed on December 30, 2022. The insurance carrier originally denied the disputed services as not medically necessary and not related to injury. These denials were not maintained.

   The insurance company provided evidence of payments in the amount of $13.63 for NDC 00904-6773-61, Acetaminophen 120 units, in the amount of $13.63 and $293.05 for NDC 27241-0098-09, Duloxetine 30 units. The requestor did not withdraw the dispute.

   The service in dispute will be reviewed per applicable fee guideline.

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
Duloxetine	27241-0098-09	G	7.851	30	$298.43	$293.05	$293.05
Acetaminophen	00904-6773-61	G	0.064	120	$13.63	$70.58	$13.63
						$363.63	$306.68

The total reimbursement is $306.68. The insurance carrier paid $306.68. 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 entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 23, 2023 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.