2-10-2023

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
Zurich American Insurance Co

MFDR Tracking Number
M4-23-3325-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 29, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 10, 2023	21922-0009-09	$115.85	$0.00
February 10, 2023	59651-0362-05	$119.15	$0.00
February 10, 2023	10702-0006-10	$160.86	$0.00
		$395.86	$0.00

Requestor's Position

"I have attached the EOB's as well as the documentation to prove that Memorial Wellness Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $395.86

Respondent's Position

The Carrier has placed the subject bill in line for reconsideration and to determine if the prescriber is authorized to treat the claimant. The Carrier will supplement this Response upon Completion of that process.

Response submitted by: Flahive, Ogden & Latson

Supplemental response submitted October 27, 2023

"Our bill audit company has determined no further payment is due."

Response submitted by: Gallagher Bassett

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

Denial Reasons

- 197 – Precertification/authorization/notification/pre-treatment absent.
- 75 – Prior authorization required.
- 05 – M((illegible) service provider number
- 85 – Claim not processed
- 88 – DUR
- 71 – Prescriber is not covered
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed on February 10, 2023. The insurance carrier denied the services as not prior authorized. DWC Rule 28 TAC §134.530 (b) Preauthorization for claims subject to the Division's closed formulary.

    (1) Preauthorization is only required for:

    (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in

Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

Review of the applicable Appendix A found.

- Diclofenac Sodium 1% gel has a status indicator of Y.
- Ibuprofen Tab 800 mg has a status indicator of Y.
- Cyclobenzaprine 5 mg tablet has a status indicator of Y.

The insurance carrier's denial is not supported. 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
Diclofenac Sodium	21922000909	G	0.58	100	$76.94	$115.85	$76.94
Ibuprofen	59651036205	G	0.685	90	$81.06	$119.15	$81.06
Cyclobenzaprine	10702000610	G	1.722	60	$133.20	$160.86	$133.20
						$395.86	$271.20

The total reimbursement is $271.20. The insurance carrier paid $291.20 on October 13, 2023 via Remit ID 456722. 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

		December 6, 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.