



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Wellness Pharmacy

Respondent Name

XL Specialty Insurance Co

MFDR Tracking Number

M4-24-0636-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

November 15, 2023

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|---------------------------------------|-------------------|------------|
| February 9, 2023 | 00406-0484-10 Acetaminophen/Cod #3 | \$81.47 | \$39.67 |
| | | \$81.47 | \$39.67 |

Requestor's Position

"The original claim was initially paid but then **REVERSED**. An appeal was submitted and received by the carrier on **08/19/2023**. See attached 2 denials for processing. The later explanation of benefits processed on 07/31/2023 states that **(Timeliness)**. There were not any additional code changes or service rendered. Therefore, the carrier cannot change from the original denial. A provider must be able to address the bill properly for continued care."

Amount in Dispute: \$81.47

Respondent's Position

The Austin carrier representative for XL Specialty Insurance Co is Flahive, Ogden and Latson. The representative was notified of this medical fee dispute on November 21, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response submitted by: N/A

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

- 60 (B13) – The provider has billed for the exact services on a previous bill.
- XD P12 – This bill was submitted after the billing timeliness guidelines provided.
- D3 (P12) – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.

Issues

1. Is the requestor's position supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed on February 9, 2023. The insurance carrier denied the claim as a duplicate and a payment was made reducing the amount paid based on reimbursement for a generic drug.

The requestor states in their position statement, The original claim was initially paid but then reversed. Review of the submitted documentation found an explanation of benefits dated March 23, 2023 that indicates a reversal was done on Prescription number 00000-42010-50. This prescription number (00000-42010-50) was found the requestors medical bill (DWC 066).

The submitted documentation supports the requestor's position. The insurance carrier did not submit a position statement in explanation of this reversal. The service in dispute will be reviewed per applicable fee guideline.

2. DWC Rule 28 TAC §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: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 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 |
|------------------------|-------------|----------------------|-------------|--------------|-------------|------------|--------------------------|
| Acetaminophen/ Codeine | 00406048401 | G | \$0.95 | 30 | \$39.67 | \$81.47 | \$39.67 |
| | | | | | | \$81.47 | \$39.67 |

The allowable fee amount is \$39.67. 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$39.67 reimbursement for the disputed services. It is ordered that XL Specialty Insurance Co must remit to Memorial Wellness Pharmacy \$39.67 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 31, 2024
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 electrónico CompConnection@tdi.texas.gov.