

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MEMORIAL WELLNESS
PHARMACY

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-24-0674-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
November 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 5, 2022	Amitriptyline HCL, Meloxicam, Methocarbamol, Omeprazole and Pharbetol	\$692.23	\$515.64

Requestor's Position

"The above claimant received medication and the carrier still has not acknowledged receipt of service. Reimbursement should be made to the provider if the claim has been submitted within the 95th day after the date on which the health care service was rendered."

Amount in Dispute: \$692.23

Respondent's Position

"The office received an initial medical bill on 2/14/2023 where an audit was performed and denied no medical to support the rationale for the use of these medications for the treatment of the compensable injury."

Response Submitted by: SORM – State office of risk management

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 Texas Administrative Code [§133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC [§134.503](#) sets out the pharmacy fee guideline.

Denial Reasons

The insurance carrier or denied the payment for the disputed services with the following claim adjustment codes:

- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable

Issues

1. Is MEMORIAL WELLNESS PHARMACY entitled to reimbursement?

Findings

1. MEMORIAL WELLNESS PHARMACY is requesting reimbursement for Amitriptylin, Meloxicam, Methocarbam, Omeprazole and OTC PharbetoI dispensed on December 5, 2022.

DWC Rule 28 Texas Administrative Code §134.503(c)(1)(A) states

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;

NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
16729017301	G	\$1.27	30	\$51.63	\$95.60	\$51.63
29300012510	G	\$4.85	30	\$185.69	\$202.85	\$185.69
31722053305	G	\$0.48	30	\$22.09	\$71.98	\$22.09
62175013643	G	\$6.69	30	\$250.88	\$258.21	\$250.88

16103035008	G	\$0.04	32	\$5.35	\$63.59	\$5.35
					Total	\$515.64

The total reimbursement is \$515.64. 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 of \$515.64 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 STATE OFFICE OF RISK MANAGEMEN must remit to MEMORIAL WELLNESS PHARMACY \$515.64 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

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 electrónico CompConnection@tdi.texas.gov.