TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Wellness Pharmacy

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-24-1646-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
April 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 3, 2023	29300-0125-10	$202.85	$185.69

Requestor's Position

"The carrier denied the original bill as well as the reconsideration based on (SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS). Memorial did not receive any additional denial codes for the rejection of this bill from the carrier. 'Rossel, Anibal' is the prescribing doctor for the claimant. I have attached the EOBs as well as the documentation to prove that Memorial Wellness Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $202.85

Respondents' Position

"This claim is enrolled in the Carrier's certified healthcare network, the First Health-Travelers HCN. The Carrier denied reimbursement as the prescribing doctor was not in the Carrier's certified healthcare network on the date of service. Dr. Anibal Rossel was previously in the Carrier's certified healthcare network but was removed from the network as of 11-30-2022. The Claimant was notified with the attached letter and selected a new Treating Doctor from the Carrier's certified healthcare network. As of the date of service at issue, Dr. Rossell was no longer in the Carrier's certified healthcare network and therefore not authorized to issue prescriptions for this HCN claim."

Response Submitted by: Travelers

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).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.
3. TLC §408.021 establishes entitlement to medical benefits.
4. 28 TAC Chapter 1305 applicable to Health Care Certified Networks.
5. Section 408.0281 sets out the reimbursement for pharmaceutical services.

Denial Reasons

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

- 243 – Services not authorized by network/primary care providers. Rx Number 6568707 reduced $202.85.
- Bill comment: This bill was a request for a 2nd review.

Issues

1. Is the insurance carrier's denial reason supported?
2. What rules apply to disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. Memorial Wellness Pharmacy seeks reimbursement for medication dispensed on April 3, 2023. The insurance carrier states the drug was denied because it was provided outside the network.

   Texas Insurance Code §1305.101 (c) states, "(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not, directly or through a contract, be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by Section 408.0281, Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation."

   Prescription medication may not, directly or through a contract, be delivered through a workers' compensation health care network.

The DWC concludes that the disputed prescription medication dispensed by the provider is not subject to the provisions of a workers' compensation health care network. Because the insurance carrier failed to support its denial of payment, Memorial Wellness Pharmacy is entitled to reimbursement for the medication rendered on April 3, 2023.

2. Rule 28 TAC §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of 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:

    • Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount.

The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price/ Unit	Units Billed	AWP Formula	Billed Amount	Lesser of AWP and Billed
Meloxicam 15 mg	29300-0125-10	G	$4.84500	30	$185.69	$202.85	$185.69

3. The DWC finds that the requestor is entitled to reimbursement in the amount of $185.69. Therefore, this amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is due. As a result, the amount ordered is $185.69.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester the amount of $185.69 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 13, 2025
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 512-804-4812.