



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requestor Name**  
Memorial Wellness  
Pharmacy

**Respondent Name**  
Zurich American Insurance Co

**MFDR Tracking Number**  
M4-24-1880-01

**Carrier's Austin Representative**  
Rep Box 19

**DWC Date Received**  
April 24, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 13, 2023	NDC # 59651-0362-05 Ibuprofen 800mg	\$98.60	\$45.10
September 13, 2023	NDC # 49483-0699-01 Acetamin 650 mg	\$72.18	\$15.48
September 13, 2023	NDC # 29300-0415-10 Cyclobenzaprine 10mg	\$90.24	\$44.93
<b>Total</b>		\$261.02	\$105.51

### Requestor's Position

"The above claimant received medication, but the carrier 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. The original bill was submitted to and received by carrier on 09/18/2023 via EMAIL CONFIRMATION."

**Amount in Dispute:** \$ 261.02

### Respondent's Position

"Zurich has denied the bill. Please see the EOBs dated September 27, 2023, and April 25, 2024. The carrier continues to rely upon the denials in its EOBs."

**Response Submitted by:** Flahive, Ogden & Latson

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Texas Labor Code §413.03](#)<sup>1</sup> and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.305](#) sets out the general procedures for medical dispute resolution.
2. [Texas Labor Code 408.021](#) details the injured worker's right to medical benefits.
3. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
4. [28 TAC §134.503](#) sets out the fee guidelines for pharmacy.

### Denial Reasons

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

- HEA1 – Claim/Service Denied
- CMR – Payment disallowed: billing error: line-item service previously processed electronically, and reimbursement/denial decision previously rendered.

### Issues

1. Is the insurance carrier's denial supported?
2. What rule is applicable to reimbursement?
3. Is requestor entitled to additional reimbursement?

### Findings

1. The requestor is seeking reimbursement of medications dispensed in September of 2023. The explanation of benefits submitted by the respondent indicates the claim/service is denied and payment denied for billing error, duplicate. These denial codes are insufficient in detailing why the claim service was denied.

Texas Labor Code, Sec. 408.021. ENTITLEMENT TO MEDICAL BENEFITS. (a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:

- (1) cures or relieves the effects naturally resulting from the compensable injury.
- (2) promotes recovery; or

- (3) enhances the ability of the employee to return to or retain employment.
- (b) Medical benefits are payable from the date of the compensable injury. Except in an emergency, all health care must be approved or recommended by the employee's treating doctor. An insurance carrier's liability for medical benefits may not be limited or terminated by agreement or settlement.

The insurance carrier did not support the reasons listed on the explanation of benefits for the denials for this medical bill. The services in dispute will be reviewed per applicable fee guidelines.,

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
Ibuprofen	59651036205	G	0.68	60	\$29.69	\$98.60	\$45.10
Acetamin	49483069901	G	0.10	90	\$15.48	\$72.18	\$15.48
Cyclobenzaprine	29300041510	G	1.09	30	\$44.93	\$90.24	\$44.93
						\$261.02	\$105.51

3. The total reimbursement is \$105.51. 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 requestor has established that additional reimbursement 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 Zurich American Insurance Co must remit to Memorial Wellness Pharmacy \$105.51 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

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Signature

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Medical Fee Dispute Resolution Officer

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June 18, 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](http://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, call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto: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](mailto:CompConnection@tdi.texas.gov).