TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-18-3732-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per Rule…"

Amount in Dispute: $183.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has submitted the medical bill in dispute for review, and an additional payment is forthcoming. The Carrier will forward a copy of the payment information once the payment is processed."

Response Submitted by: Downs Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 22, 2017	Tramadol Tablet, Ibuprofen Tablet	$183.26	$85.26

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced the disputed services with the following claim adjustment codes:
    - HE75 – Prior authorization required

Issues

1. Is the respondent's position supported?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The respondent states in their position, "The carrier has submitted the medical bill in dispute for review, and an additional payment is forthcoming." This response to MFDR was dated June 13, 2018. No additional indication of payment has been received to date. The services in dispute will be reviewed per applicable fee guideline.

2. The requestor is seeking reimbursement of $183.26 for medication dispensed September 22, 2017. The carrier denied the claim as HE75 – "Prior authorization required."

   For the dates of service in dispute the applicable rule is 28 Texas Administrative Code §134.530(b)(1)(A) which states that preauthorization is **only** required for:

   - 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;

   The division finds that the medication rendered on the date of service in question does not include a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. Therefore, the division concludes that the medication in question did not require preauthorization and the carrier's denial of payment for this reason is not supported. Therefore, the disputed services will be reviewed for reimbursement.

3. 28 Texas Administrative Code §134.503 (c) applies to the compounds in dispute and 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;

Ingredient	NDC	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Tramadol 50 mg table	69543013611	$0.83	60	$62.46	$107.47	$62.46
Ibuprofen 800 mg table	55111068405	$0.30	60	$22.80	$75.79	$22.80
					Total	$85.26

The total reimbursement is $85.26. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $85.26.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $85.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 7, 2018
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.