TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-19-0053-01

Carrier's Austin Representative
Box 19

MFDR Date Received
September 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization. These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $483.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Relatedness Dispute is unresolved."

Response submitted by: Flahive, Ogden, Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 26, 2017	Tizanidine, Ibuprofen, Gabpentin, Acetaminopehn/Cod #3	$483.16	$275.51

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 §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.540 sets out the closed formulary requirements for claims subject to certified networks.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 - Payment denied/reduced for absence of precertification/authorization

- 5085 - Payment is denied as the billed diagnosis is not allowed in this claim

Issues

1. Is the insurance carrier's reason(s) for denial of payment supported?
2. Is the health care provider entitled to reimbursement of the disputed services?

Findings

1. The requestor is seeking reimbursement of medication provided December 26, 2017. The insurance carrier denied the disputed service based on lack of pre-authorization and diagnosis not allowed.

   28 Texas Administrative Code §134.540(b) states that preauthorization is only required for:

   (1) 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;

   Review of the disputed services found the requestor was not required to seek preauthorization pursuant to §134.540(b)(2) because none of the oral medication have a status of "N" in the current edition of the ODG/Appendix A.

   Regarding the other denial of "not allowed" diagnosis. 28 TAC 133.240 (h) states,

   An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:

   (3) the condition for which the health care was provided was not related to the compensable injury.

   Review of the submitted documents found insufficient evidence to support the required notice was issued. This denial and the respondent's position of "relatedness dispute is unresolved" will not be considered in this review.

2. 28 Texas Administrative Code §134.503 applies to the services 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;

   Reimbursement is calculated as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Tizanidine HCL	60505025202	G	$1.47	60	$95.83	$145.41	$95.83
Ibuprofen	55111068405	G	$0.30	90	$29.90	$84.93	$29.90
Gabapentin	65162010250	G	$1.34	90	$131.45	$178.26	$131.45
Acetaminophen/Cod	00093015010	G	$0.28	60	$18.31	$74.56	$18.31
						Total	$275.51

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 $275.51

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 $275.51, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		May 20, 2019
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.