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
Old Republic Insurance Company

MFDR Tracking Number
M4-19-0616-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
October 3, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $352.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2018	Zolpidem Tartrate 10 mg Tablets	$196.25	$177.44
January 31, 2018	Prednisone 20 mg Tablets	$65.27	$13.71
January 31, 2018	Acetaminophen/Codeine #4 Tablets	$90.61	$45.39
	Total	$352.13	$236.54

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. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulationms or payment policies, use only if no other code is applicable.

- HE75 – Prior Authorization require to process this bill.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Is the insurance carrier's reason for denial of payment based on preauthorization supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. The insurance carrier's Austin representative acknowledged receipt of the copy of this medical fee dispute on October 11, 2018. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. If a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.[1]

   No response has been received on behalf of Old Republic Insurance Company to date. For that reason, the decision will be based on the information available.

2. The insurance carrier denied the disputed drugs based on preauthorization. Preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A[2];
   - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A; and
   - any investigational or experimental drug.[3]

   The division finds that the drugs in question are not identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, these drugs do not require preauthorization per 28 TAC §134.530(b)(2)(A).

   The submitted documentation does not support that the drugs in question constitute a compound drug. Therefore, this drug does not require preauthorization per 28 TAC §134.530(b)(2)(B).

   The submitted documentation does not support that the drugs in question are experimental or investigational. Therefore, these drugs do not require preauthorization per 28 TAC §134.530(b)(2)(C).

   The division concludes that the insurance carrier's denial of payment of Zolpidem Tartrate 10 mg tablets, Prednisone 20 mg tablets, and Acetaminophen/Codeine #4 tablets is not supported.

3. Because the insurance carrier failed to support its denial of payment, Memorial is entitled to reimbursement for the drug in question.

   The reimbursement considered in this dispute is calculated as follows[4]:

   - Zolpidem Tartrate 10 mg tablets: (4.6251 x 30 x 1.25) + $4.00 = $177.44
   - Prednisone 20 mg tablets: (0.259 x 30 x 1.25) + $4.00 = $13.71
   - Acetaminophen/Codeine #4 tablets: (0.55186 x 60 x 1.25) + $4.00 = $45.39

   The total reimbursement is therefore $236.54. This amount is recommended.

Conclusion

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 $236.54.

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[1] 28 Texas Administrative Code §133.307(d)(1)
[2] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[3] 28 Texas Administrative Code §134.540(b)
[4] 28 Texas Administrative Code §134.503(c)

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 $236.54, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	February 22, 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.