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
Zurich American Insurance Co

MFDR Tracking Number
M4-19-1466-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization or preauthorization was absent."

Amount in Dispute: $75.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The extent of Injury/Relatedness Dispute is unresolved"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2018	Ibuprofen 800 mg tablet	$75.79	$23.06

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 prior authorization requirement for pharmacy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 39 – Services denied at the time authorization/pre-certification was requested

Issues

1. Did the insurance carrier raise a new issue?
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 Extent of Injury/Relatedness Dispute is unresolved." Review of the submitted information found the insurance carrier did not deny the disputed charges based on extent rather the lack of preauthorization. 28 TAC §133.307 (d) (2) (F) states,

    > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section

    Review of the documentation submitted pertained to compound medication and not for the date of service in dispute. The carrier's position will not be considered in this review.

2. The requestor is seeking reimbursement of $75.79 for an oral medication dispensed March 7, 2018. The carrier denied the disputed compound based on prior authorization was denied.

    28 Texas Administrative Code §134.530(b)(1)(A) which states that preauthorization is **only** required for:

    > 1) Preauthorization is only required for:
    >
    > (A) 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 is not a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. The submitted denials of authorization were not for the medication in dispute or the date of service in dispute. The service in dispute will be reviewed per applicable fee guideline.

3. 28 Texas Administrative Code §134.503 (c) applies to the medication 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;

    The maximum allowable reimbursement is shown below;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Ibuprofen	55111068405	G	$0.31	60	$23.06	$75.79	$23.06
						Total	$23.06

The total reimbursement is $23.06. 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 $23.06.

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 $23.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		August 29, 2019

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.