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
Merged Royal Insurance Company of America Into Arrowood Indemnity

MFDR Tracking Number
M4-19-3157-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
February 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $107.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Utilization review was completed on 05/02/2018 by ezURs for the Tramadol HCL 50mg and was adverse. Therefore, bill was denied per adverse determination."

Response Submitted by: Arrowpoint Capital

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2018	Tramadol HCl 50 mg Tablets	$107.78	$66.85

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:
   - 39 – Services denied at the time authorization/pre-certification was requested.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is the insurance carrier's denial of payment based on preauthorization supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. Memorial is seeking reimbursement for Tramadol HCl 50 mg tablets dispensed on October 5, 2018. In its position statement, the insurance carrier argued that the drug in question was denied based on medical necessity.

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the division. Any new denial reasons or defenses raised shall not be considered for review.[1]

   The submitted documentation does not support that a denial based on medical necessity was provided to Memorial before this request for MFDR was filed. Therefore, the division will not consider this argument in the current dispute review as this issue constitutes a new defense.

2. The insurance carrier denied the disputed drug 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 drug in question is not identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization per 28 TAC §134.530(b)(2)(A).

   The submitted documentation does not support that the drug in question constitutes 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 disputed drug is experimental or investigational. Therefore, this drug does not require preauthorization per 28 TAC §134.530(b)(2)(C).

   The division concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization 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]:

   - Tramadol 50 mg tablets: (0.838 x 60 x 1.25) + $4.00 = $66.85

   The total reimbursement is therefore $66.85. 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 $66.85.

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[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 $66.85, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	March 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.