



# 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**

American Casualty Company Reading PA

**MFDR Tracking Number**

M4-19-3561-01

**Carrier's Austin Representative**

Box Number 57

**MFDR Date Received**

March 25, 2019

### REQUESTOR'S POSITION SUMMARY

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

**Amount in Dispute:** \$155.33

### 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
October 22, 2018	Promethazine 25 mg Tablets	\$72.69	\$0.00
October 24, 2018	Tramadol HCl 50 mg Tablets	\$82.64	\$35.43
	Tablet	\$155.33	\$35.43

### 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 Codes §§134.530 and 134.540 set out the guidelines for preauthorization of pharmaceutical services.
4. The insurance carrier denied payment of the drugs in question based on preauthorization.

## Issues

1. Did American Casualty Company of Reading PA respond to the medical fee dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement?

## Findings

1. The Austin carrier representative for American Casualty Company of Reading PA is Continental Casualty Company. Continental Casualty Company acknowledged receipt of the copy of this medical fee dispute on April 2, 2019. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. Memorial is seeking reimbursement for Promethazine 25 mg tablets dispensed on October 22, 2018, and Tramadol HCl 50 mg tablets dispensed on October 24, 2018. Preauthorization is only required for:
  - drugs identified with a status of "N" in the current edition of the ODG Appendix A<sup>1</sup>;
  - any prescription drug created through compounding prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A;
  - any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
  - any investigational or experimental drug.<sup>2</sup>

The DWC finds that Promethazine is identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, this drug requires preauthorization prior to dispense.

The DWC finds that Tramadol HCl is not identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization.<sup>3</sup>

The DWC finds that the drugs in question do not constitute a compound. Therefore, these drugs do not require preauthorization.<sup>4</sup>

The submitted documentation does not support that the disputed drugs are experimental or investigational. Therefore, these drugs do not require preauthorization.<sup>5</sup>

The DWC concludes that the insurance carrier's denial of payment for Promethazine 25 mg tablets is supported. No reimbursement for this drug can be recommended.

The DWC concludes that the insurance carrier's denial of payment for Tramadol HCl 50 mg tablets is not supported.

3. Because the insurance carrier failed to support its denial of payment Tramadol HCl 50 mg tablets, Memorial is entitled to reimbursement for this drug.

The reimbursement considered in this dispute is calculated as follows<sup>6</sup>:

- Tramadol HCl 50 mg tablets:  $(0838 \times 30 \times 1.25) + \$4.00 = \$35.43$

The total reimbursement is therefore \$35.43. This amount is recommended.

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<sup>1</sup> ODG *Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*

<sup>2</sup> 28 TAC §134.530(b)(1) and §134.540(b)

<sup>3</sup> 28 TAC §134.530(b)(1)(A) and §134.540(b)(1)

<sup>4</sup> 28 TAC §§134.530(b)(1)(B) and (C), and §134.540(b)(1) and (2)

<sup>5</sup> 28 TAC §134.530(b)(1)(D) and §134.540(b)(4)

<sup>6</sup> 28 Texas Administrative Code §134.503(c)

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$35.43.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor \$35.43, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

	Laurie Garnes	July 30, 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.**