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
New Hampshire Insurance Co

MFDR Tracking Number
M4-19-4117-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Labor Code Section 408.027 (b) requires that the carrier must pay, reduce, deny or determine to audit the health provider's claim no later than the 45th day after the receipt by the carrier. Memorial did not receive any correspondence as per rule…"

Amount in Dispute: $293.11

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
February 1, 2019	Cyclobenzaprine 10 mg, Meloxicam	$293.11	$222.75

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:
   - 197 – "Precertification/authorization/notification absent"

Issues

1. Is the requestor's position supported?
2. Did the insurance carrier raise a new issue?
3. Is the insurance carrier's reason for denial of payment supported?
4. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor states, "Memorial did not receive any correspondence as per rule…" Review of the submitted documents found explanation of benefits were processed and issued on March 7, 2019 and April 8, 2019 both of which were prior to the request for MFDR received on May 13, 2019. The requestors' position is not supported and will not be considered in this review.

2. The respondent states in their position, "The Requestor states, "The Extent of Injury/Relatedness Dispute is unresolved." 28 TAC §133.307 (2) (F) states in pertinent part,

   > 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.

   Review of the submitted documentation found explanation of benefits were issued with the denial code 197 – "Payment denied/reduced for absence of precertification/authorization." This denial reason only will be considered in this review.

3. The requestor is seeking reimbursement of $293.11 for oral medication dispensed on February 1, 2019. The carrier denied the disputed medication based on lack of preauthorization.

   For the dates of service in dispute the applicable rule is 28 Texas Administrative Code §134.530(b)(1)(A) which states that preauthorization is **only** required for:

   - 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 are not drugs identified with a status of "N" in the current edition of the ODG, *Appendix A*.

   The carrier's denial of payment for this reason is not supported. The disputed medication will be reviewed for reimbursement.

4. 28 Texas Administrative Code §134.503 (c) applies to the compounds 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;
   (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or

The applicable fee is calculated below.

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed / Tablets	AWP Formula	Billed Amt	Lesser of AWP and Billed
Cyclobenzaprine	65162054150	G	$1.09	30	$40.88	$90.26	$40.88
Meloxicam	29300012510	G	$4.85	30	$181.88	$202.85	$181.88
						Total	$222.75

The total reimbursement is $222.75. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

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 $222.75.

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 $222.75, 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	July 18, 2019 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.