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 Co

MFDR Tracking Number
M4-19-4121-01

Carrier's Austin Representative
Box Number 44

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 not later than the 45th day after the date of receipt by the carrier. Memorial did not receive any correspondence as per rule…"

Amount in Dispute: $746.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bills for these prescriptions were denied as the prescribing doctor is not an authorized doctor on this network claim."

Response Submitted by: White Espey

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2019	Prescribed oral medication	$746.87	$638.94

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

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 attached Explanation of Review and email from the adjuster note the reasons for denial as the provider was not authorized to perform services for the network." Review of the explanation of benefits printed May 22, 2019 only included the explanation "Payment denied/reduce for absence of precertification/authorization." No mention of network was found. The respondent's position is not supported and will not be considered in this review.

2. The requestor is seeking reimbursement for oral medication dispensed February 21, 2019 in the amount of $746.87. The insurance carrier denied the service based on lack of authorization.

   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;

   Review of the submitted medical claim and Appendix A found none of the dispensed medication is a "N" drug. The insurance carrier's denial is not supported. The service in dispute will be reviewed per applicable fee guideline.

3. 28 Texas Administrative Code §134.503 (c) 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)

Ingredient	NDC	Generic(G) /Brand(B)	Price/ Unit	Units billed	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Acetaminophen	00093015010	G	$0.28	60	$21.33	$74.56	$21.33
Cyclobenzaprine	10702000610	G	$1.72	30	$64.50	$109.18	$64.50
Meloxicam	29300012410	G	$3.17	60	$237.60	$247.62	$237.60
Omeprazole	68462039610	G	$4.30	60	$322.50	$315.51	$315.51
						Total	$638.94

The total reimbursement is $638.94. 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 $638.94.

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 $638.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 27, 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.