



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

Starr Insurance Co

MFDR Tracking Number

M4-19-4175-01

Carrier's Austin Representative

Box Number 48

MFDR Date Received

May 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied for (pre-authorization).

Amount in Dispute: \$88.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Nothing in the system or in the claimants file to indicate adjuster has requested to override this denial decision."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 28, 2019, Cyclobenzaprine 10 mg tablets, \$88.62, \$33.91

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. Is the insurance carrier’s reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the compound in question?

**Findings**

1. The requestor is seeking reimbursement of \$88.62 for Cyclobenzaprine 10 mg tablets dispensed February 28, 2019. The insurance carrier denied for lack of authorization.

For the date 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.

2. 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)
Cyclobenzaprine	65162054111	G	\$1.04	30	\$33.91	\$88.62	\$33.91
						Total	\$33.91

The total reimbursement is \$33.91. 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 \$33.91.

***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 \$33.91, 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

\_\_\_\_\_  
June 27, 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.**