



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 Company

MFDR Tracking Number

M4-19-4730-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

July 1, 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: \$798.55

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: Old Republic Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2019	Acetaminophen/Codeine #3 Tablets	\$74.56	\$25.33
March 21, 2019	Meloxicam 7.5 mg Tablets	\$247.62	\$241.65
March 21, 2019	Omeprazole DR 20 mg Capsules	\$315.51	\$315.51
March 21, 2019	Cyclobenzaprine 5 mg Tablets	\$160.86	\$133.20
Total		\$798.55	\$715.69

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Codes §§134.530 and 134.540 set out the guidelines for preauthorization of pharmaceutical services.

4. Texas Labor Code §408.021 establishes entitlement to medical benefits.
5. Texas Insurance Code §1305.101 defines the duties of networks to provide medical treatment.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 242 – Services not provided by network/primary care providers.
 - 197 – Payment denied/reduced for absence of precertification/authorization.
 - 881 – Payment is denied because the service was performed by provider outside the client’s MPN Network.
 - 5264 – Payment is denied-service not authorized

Issues

1. Is the insurance carrier’s denial of payment based on network care supported?
2. Is the insurance carrier’s reason for denial of payment based on preauthorization supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on March 21, 2019. The insurance carrier reimbursement, in part, asserting that the drugs were provided outside the certified health care network.

Prescription medication may not, directly or through a contract, be delivered through a workers’ compensation health care network.¹

The DWC concludes that the disputed prescription medication dispensed by the provider in this case – Memorial Compounding Pharmacy – is not subject to the provisions of a workers’ compensation health care network. Service Lloyds Insurance Company’s denial for this reason is not supported.

2. Submitted documentation indicates that 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 A²;
- any compound 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.³

The DWC finds that the drugs in question are not identified with a status of “N” in the applicable edition of the ODG, *Appendix A*. Therefore, these drugs do not require preauthorization for this reason.⁴

The submitted documentation do not support that the disputed drugs are not a compound. Therefore, these drugs do not require preauthorization for this reason.⁵

The submitted documentation does not support that the disputed drugs are experimental or investigational. Therefore, these drugs do not require preauthorization for this reason.⁶

The DWC concludes that the insurance carrier’s denial of payment of the disputed drugs based on preauthorization is not supported.

3. Because the insurance carrier failed to support its denial of payment for the disputed drugs, Memorial is entitled to reimbursement.

¹ Texas Insurance Code §1305.101(c)

² *ODG Treatment in Workers’ Comp (ODG) / Appendix A, ODG Workers’ Compensation Drug Formulary*

³ 28 TAC §134.530(b)(1) and §134.540(b)

⁴ 28 TAC §134.530(b)(1)(A) and §134.540(b)(1)

⁵ 28 TAC §134.530(b)(1)(B) and (C), and §134.540(b)(2) and (3)

⁶ 28 TAC §134.530(b)(1)(D) and §134.540(b)(4)

The reimbursement considered in this dispute is calculated as follows⁷:

- Acetaminophen/codeine #3 tablets: $(0.28435 \times 60 \times 1.25) + \$4.00 = \$25.33$
- Meloxicam 7.5 mg tablets: $(3.1687 \times 60 \times 1.25) + \$4.00 = \$241.65$
- Omeprazole DR 20 mg capsules: $(4.3002 \times 60 \times 1.25) + \$4.00 = \$326.52$
Memorial is seeking \$315.51 for this drug. No additional reimbursement will be recommended.
- Cyclobenzaprine HCl 5 mg tablets: $(1.7226 \times 60 \times 1.25) + \$4.00 = \$133.20$

The total reimbursement is therefore \$715.69. This amount is recommended.

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 \$715.69.

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 \$715.69, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.

⁷ 28 Texas Administrative Code §134.503(c)