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
XL Insurance America Inc

MFDR Tracking Number
M4-19-4946-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization…"

Amount in Dispute: $345.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bills in question for bill review audit and payment."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2019	Meloxicam, Sertraline	$345.89	$0.00

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 §134.530 sets out prior authorization requirement for pharmacy services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Pre-certification/authorization/notification/pre-treatment absent

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking reimbursement of $345.89 for oral medications the insurance carrier denied based on lack of prior authorization.

   28 TAC §134.530(b)(1)(A) states that preauthorization is 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 applicable Appendix A found Meloxicam is listed as a (N) drug and Sertraline is also listed as a (N) drug.

   The requestor submitted insufficient evidence to support their position that the medications do not require prior authorization.

   The insurance carriers' denial is supported no additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 9, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.