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
Norguard Insurance Co

MFDR Tracking Number
M4-19-4989-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
July 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have attached the EOB's as well as the documentation to prove that Memorial Compounding Pharmacy has met the requirements for reimbursement."

Amount in Dispute: $700.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2109	Oral medication	$700.47	$415.26

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:
   - 18 – Exact duplicate
   - 193 – Original payment decision is being maintained
   - 197 – Precertification/authorization/notification/pre-treatment absent

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 for three oral medications dispensed on May 16, 2019. The insurance carrier denied the medication based on lack of preauthorization.

   The applicable rule 28 TAC §134.530(b)(1)(A) defines drugs identified with a status of "N" require preauthorization. Review of the three medications found;

   - Gabapentin – no authorization required
   - Meloxicam – authorization required
   - Omeprazole – no authorization required

   Based on the above, the denial for Meloxicam is upheld. There was insufficient evidence submitted to support that this medication is not identified as a "N" drug.

   The other medications, Gabapentin and Omeprazole will be reviewed per applicable fee guideline.

   The fee guideline is found at 28 TAC §134.503 (c) (1) and is 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: Generic drugs: ((AWP per unit) x (number of units) x 1.25).

   The calculation of the fee based on the above is as follows.

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Gabapentin	67877022305	G	$1.33	60	$99.75	$137.34	$99.75
Omeprazole	68462039610	G	$4.30	60	$322.50	$315.51	$315.51
						Total	$415.26

The total reimbursement is $415.26. This amount is recommended.

Conclusion

For the reasons stated above, DWC finds that additional reimbursement is due. The amount ordered is $415.26.

ORDER

The division hereby ORDERS the respondent to remit to the requestor $415.26, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

		October 9, 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 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.