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 RX

Respondent Name
Property & Casualty Insurance Company of America

MFDR Tracking Number
M4-20-0915-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
December 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $67.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Denial was issued as we do not have any medical reports from the Claimant's Doctor that show the Doctor prescribing this medication for the workers' compensation injury."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2019	Acetaminophen/Codeine #3 Tablets	$67.17	$16.08

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 (DWC).

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 Codes §§134.530 and 134.540 set out the closed formulary requirements.
4. The insurance carrier denied payment for the disputed drug based on preauthorization.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is the insurance carrier's denial of payment based on preauthorization supported?
3. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. In its position statement, The Hartford, on behalf of the insurance carrier, argued that "Denial was issued as we do not have any medical reports from the Claimant's Doctor that show the Doctor prescribing this medication for the workers' compensation injury."

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.[1]

   The submitted documentation does not support that a denial based on relatedness to the compensable injury was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Memorial is seeking reimbursement for Acetaminophen/Codeine #3 tablets dispensed on August 26, 2019. Property & Casualty Insurance Company of America denied the drug based on preauthorization. Preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG, Appendix A[2];
   - 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]

   Review of the ODG, Appendix A finds that the drug in question does not have a status of "N". No evidence was provided to indicate that the drug in question is a compound drug.

   The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review.[4] The Hartford provided no argument or evidence that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific drug considered in this review is investigational or experimental.

   The DWC finds that the insurance carrier failed to support that the drug in question required preauthorization.

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

   The reimbursement considered in this dispute is calculated as follows[5]:

   - Acetaminophen/Codeine #3 tablets: (0.48331 x 20 x 1.25) + $4.00 = $16.08

   The total allowable reimbursement is $16.08. This amount is recommended.

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[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] Texas Insurance Code §19.2005(b)
[5] 28 Texas Administrative Code §134.503(c)

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 $16.08.

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 $16.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	January 9, 2020
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.