



# 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**

Safety National Casualty Corp

**MFDR Tracking Number**

M4-20-1963-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

April 13, 2020

### 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 to receive reimbursement."

**Amount in Dispute:** \$69.44

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for bill review and payment. Supplemental response will be provided once the bill auditing company has finalized their review."

**Response Submitted by:** Gallagher Bassett

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 21, 2020	Oral medication	\$69.44	\$14.93

### 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 Code §134.530 sets out requirements of prior authorization.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 00438 (197)Precertificaton/authorization/notification/pre-treatment absent

**Issues**

1. Is the insurance carrier’s denial supported?
2. What rule applies to disputed service?

**Findings**

1. The requestor is seeking reimbursement for oral medication dispensed January 21, 2020. The insurance carrier denied for lack of preauthorization. 28 TAC §134.530 (b)(1)(A) states in pertinent 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*.

Review of the Appendix A ODG Drug Formulary for the date of service in dispute found the oral medication “Tramadol” does not have a status of “N”. The insurance carrier’s denial is not supported. The service in dispute will be reviewed per applicable fee guideline.

2. 28 TAC §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of 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:
  - Generic drugs: ((AWP per unit) x (number of units) x 1.25) + \$4.00 dispensing fee per prescription = reimbursement amount;
  - Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + \$4.00 dispensing fee per prescription = reimbursement amount;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Tramadol	57664037718	G	0.796	15	\$14.93	\$69.44	\$14.93

The total reimbursement is \$14.93. This amount is recommended.

**Conclusion**

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

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 \$14.93.

***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 \$14.93, 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

July 31, 2020  
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.**