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
STATE NATIONAL INSURANCE CO

MFDR Tracking Number
M4-20-2377-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 26, 2020

REQUESTOR'S POSITION SUMMARY

"… Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $184.05

RESPONDENT'S POSITION SUMMARY

"The issue of extent of injury/relatedness has been joined, and the disputed services have not yet been determined to be for the compensable injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12, 2020	Tamsulosin HCl 0.4 mg Capsules	$184.05	$162.19

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 preauthorization requirements for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 285 – Please refer to the note above for a detailed explanation of the reduction.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Notes: "Service not authorize"
   - W3 – Additional payment made on appeal/reconsideration.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1241 – No additional reimbursement allowed after review of appeal/reconsideration/request for second review.

Issues

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

Findings

1. Memorial is seeking reimbursement for Tamsulosin HCl dispensed on March 12, 2020. In its position statement, Flahive, Ogden & Latson, on behalf of the insurance carrier, argued that "The issue of extent of injury/relatedness has been joined, and the disputed services have not yet been determined to be for the compensable injury."

   The response from the insurance carrier is required to address only the denial reasons presented to the health care provider before to the request for medical fee dispute resolution (MFDR) was filed with the 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 extent of 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. 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 A[2];
   - any prescription drug created through compounding prescribed before July 1, 2018 that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A, and any updates;
   - 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 drug is not identified with a status of "N" in the current edition of the ODG Appendix A.

   No evidence was presented to support that the drug in question was investigational or experimental. The insurance carrier's preauthorization denial is therefore not supported.

3. Because State National Insurance Company failed to support its denial reason for the service in this dispute, the DWC finds that Memorial is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[4]:

   - Tamsulosin HCl 0.4 mg capsuls: (4.2183 x 30 x 1.25) + $4.00 = $162.19

   The total allowable reimbursement is $162.19. 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 $162.19.

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[1] 28 TAC §133.307 (d)(2)(F)
[2] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[3] 28 Texas Administrative Codes §§134.530 (b)(1) 134.540 (b)
[4] 28 TAC §134.503 (c)

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 $162.19, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 29, 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.