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

Requester Name
MEMORIAL COMPOUNDING RX

Respondent Name
STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number
M4-20-2416-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 4, 2020

REQUESTER'S POSITION SUMMARY

"The original claim was denied on **04/02/2020** with denial code **00438** based on **PREAUTHORIZATION**. **An appeal** was submitted on **03/27/2020** … the explanation of benefits states that code **00663**, based on **FEE SCHEDULE GUIDELINES**, is the new denial reason."

Amount in Dispute: $72.00

RESPONDENT'S POSITION SUMMARY

Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2020	Acetaminophen/codeine #3 Tablets	$72.00	$22.12

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:
   - 00438 – (197) Precertification/authorization/notification/pre-treatment absent.
   - 00663 – Reimbursement has bee calculated according to state fee schedule guidelines.
   - 86 – (18) Exact duplicate claim/service.

Issues

1. Did Starr Indemnity and Liability Company respond to the medical fee dispute?
2. Is Starr Indemnity and Liability Company's denial of payment for the drug in question supported?
3. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Starr Indemnity and Liability Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on June 8, 2020. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Memorial is seeking reimbursement for Acetaminophen/codeine #3 tablets dispensed on March 20, 2020.

   Submitted documentation indicates that 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 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]

   The DWC finds that the drug in question is not identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization for this reason.[4]

   The submitted documentation does not support that the disputed drug is a compound. Therefore, this drug does not require preauthorization for this reason.[5]

   The submitted documentation does not support that the disputed drug is experimental or investigational. Therefore, this drug does not require preauthorization for this reason.[6]

   The DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is not supported.

3. Because Starr Indemnity and Liability 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[7]:

   - Acetaminophen/codeine #3 tablets: (0.48331 x 30 x 1.25) + $4.00 = $22.12

   The total allowable reimbursement is $22.12. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requester has established that additional reimbursement is due. As a result, the amount ordered is $22.12.

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[1] 28 TAC §133.307(d)(1)
[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] 28 TAC §134.530(b)(1)(A) and §134.540(b)(1)
[5] 28 TAC §134.530(b)(1)(B) and (C), and §134.540(b)(2) and (3)
[6] 28 TAC §134.530(b)(1)(D) and §134.540(b)(4)
[7] 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 requester is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requester $22.12, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		September 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.