TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING RX

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-20-2878-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 6, 2020

REQUESTOR'S POSITION SUMMARY

"The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $86.50

RESPONDENT'S POSITION SUMMARY

"Respondent has disputed the bill in dispute as the medication was for conditions not related to the compensable injury, but instead related to disputed conditions."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2020	Acetaminophen/Codeine #3 Tablets	$86.50	$40.25

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:
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - 5264 – Payment is denied – service not authorized.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is the insurance carrier's denial of payment for the disputed drug supported?
3. Is Memorial Compounding Rx (Memorial) entitled to reimbursement for the drug in question?

Findings

1. In its position statement, Downs-Stanford, P.C., on behalf of the insurance carrier, argued that "Respondent has disputed the bill in dispute as the medication was for conditions not related to the compensable injury, but instead related to disputed conditions."

   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 the 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. Memorial is seeking reimbursement for Acetaminophen/Codeine #3 tablets dispensed on April 9, 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 the insurance carrier 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 60 x 1.25) + $4.00 = $40.25

   The total allowable reimbursement is $40.25. This amount is recommended.

---

[1] 28 TAC §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] 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)

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 $40.25.

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 $40.25, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		September 8, 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.