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
Work First Casualty Co

MFDR Tracking Number
M4-21-0145-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 30, 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: $608.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Work First Casualty Co is Flahive Ogden & Latson who was of this medical fee dispute on October 6, 2020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 3, 2020	Oral medication	$608.77	$109.89

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §315 sets out requirements of Texas State Board of Pharmacy.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D3 – The charge for the prescription drug is greater than the maximum reimbursement for a generic drug

- E1 – The provider does not appear to have a valid Drug Enforcement Agency (DEA) ID on file. As the service rendered is a drug item classified by the DEA as a federally controlled substance. It is recommended the provider submit an updated DEA ID in order to remain compliant.
- TERM – Date of service after coverage ended.

Issues

1. Is the insurance carrier's denials supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed June 3, 2020. The insurance company denied the services in dispute with several denial reasons. Review of the submitted documentation found the following:
    - The insurance carrier included as part of the explanation of benefits TERM – date of service after coverage ended. Insufficient evidence found to support this denial. The services in dispute will be reviewed per applicable fee guideline.
    - The insurance carrier denied as no valid DEA number. Two of the disputed medications Pregabalin and Tramadol were found in the Drug Enforcement Agency (DEA) drug classification listing as a controlled substance. Texas Administrative Code Rule §315.12 (b) states, "If a written prescription form is to be used to prescribe a controlled substance the **dispensing practitioner must be registered with the DEA under both state and federal law to prescribe controlled substances**. Insufficient evidence was found to support the requestor met the required registration. The insurance carrier's denial is supported.
    - The carrier indicated denial of the medication Tizanidine as charge being greater than the maximum of a generic drug but made no payment. This medication will be reviewed per applicable fee guideline.
2. 28 Texas Administrative Code §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;

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Tizanidine	29300016910	G	1.465	60	$109.89	$145.41	$109.89

The total reimbursement is $109.89. 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 $109.89.

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 $109.89, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 15, 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 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.