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
OLD REPUBLIC NSURANCE COMPANY

MFDR Tracking Number
M4-21-1266-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
March 24, 2021

Response Submitted by:
No Response Submitted

REQUESTOR'S POSITION SUMMARY

"Memorial Compounding has provided service and met all requirements to received reimbursement."

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Old Republic Insurance Company is White Espey, P.L.L.C. White Espey, P.L.L.C., was notified of this medical fee dispute on March 30, 2021. 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
December 16, 2020	Prescribed Medications	$554.37	$409.45

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier denied/reduced the services in dispute with the following denial/reduction codes:
   - D3-P12 - The charge for the prescription drug is greater than the maximum reimbursement for a generic drug.
   - NRCN - The bill has been reconsidered and no additional money is due.
   - E1-P12 - 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.

- E3-P12 - The provider dispensed a drug item classified by the Drug Enforcement Agency (DEA) as a federally controlled substance with a DEA Class of CI, CII, or CV. The Controlled Substances Act monitors their classes of drugs due to the high abuse potential.

Issues

1. Are the insurance carrier's denial reasons E1-P12 and E3-P12 supported?
2. Is Memorial entitled to reimbursement for the prescribed medications?

Findings

1. The disputed medication Hydrocodone was denied as no valid DEA number. The DWC found Hydrocodone in the Drug Enforcement Agency (DEA) drug classification listing as a controlled substance. TAC §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." The DWC found Insufficient evidence to support that the required registration was met. The insurance carrier's denial is supported, and therefore, reimbursement cannot be recommended.
2. The requestor seeks reimbursement in the amount of $436.16 for Meloxicam and Tizanidine HCL dispensed on December 16, 2020. The insurance carrier denied the services in dispute with denial reduction codes NRCN and D3-P12 (description provided above.) The DWC found no evidence that services in dispute are not covered under the Texas Workers' Compensation formulary. Therefore, the DWC finds that Memorial is entitled to reimbursement for these drugs.

   Per 28 TAC §134.503 (c) states the insurance carrier shall reimburse the healthcare 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.

   The reimbursement considered in this dispute is calculated as follows[3]:

   - Meloxicam 15 mg: (4.84500 x 30 x 1.25) + $4.00 = $185.69
   - Tizanidine HCL 4 mg: (1.46507 x 120 x 1.25) + $4.00 = $223.76

   The total allowable reimbursement is $409.45. 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 $409.45.

[1] 28 TAC §133.307 (d)(2)(F)
[2] 28 TAC §134.503 (c)
[3] 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 $409.45, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 18, 2021
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.