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**
XL INSURANCE AMERICA INC.

**MFDR Tracking Number**
M4-21-1439-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
April 15, 2021

**Response Submitted by:**
Gallagher Bassett

## *REQUESTOR'S POSITION SUMMARY*

"The above claimant received medication as prescribed by referral provider. Bill for date of service 02/05/2021 was denied indicating lack of preauthorization. These medications do not require preauthorization therefore do not need a retrospective review."

## *RESPONDENT'S POSITION SUMMARY*

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for bill review audit and payment. Supplemental response will be provided once the bill auditing company has finalized their review. Attached is a copy of all bills received to date, and their corresponding EOB's and payment details."

## *SUMMARY OF DISPUTED SERVICE(S)*

| Date(s) of Service | Disputed Service(s) | Amount in Dispute | Amount Due |
|---|---|---|---|
| February 5, 2021 | Omeprazole | $158.70 | $130.50 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §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 reduced payment for the disputed services with the following claim adjustment codes:
   - 00663 – REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES
   - 438 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATIONIAUTHORIZATION
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATIONIAUTHORIZATION.
   - 5725 – First Script has denied the line for Utilization. For questions, please call 1-888-232-0958.

**Issue(s)**
What is the applicable rule for determining reimbursement for the medication in dispute?

**Findings**

The requestor is seeking reimbursement for oral medication dispensed February 5, 2021. The insurance carrier denied the medication due to lack of authorization.

28 TAC §134.530 (b) states in pertinent part that preauthorization is only required for drugs identified with a status on "N" in the current edition of the ODG Treatment Comp (ODG) / Appendix A. Review of Appendix A for the date of service in dispute found the medication, Omeprazole is not listed as a "N" drug. The insurance carrier's denial is not supported, the service in dispute will be reviewed per applicable fee guideline

28 TAC §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 |
|---|---|---|---|---|---|---|---|
| Omeprazole | 62175011843 | G | 3.37338 | 30 | $130.50 | $158.70 | $130.50 |

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 reimbursement is due. As a result, $130.50 is due.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $130.50 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | July 6, 2021<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 TAC §133.307, 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 with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.