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 Pharmacy

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-21-1772-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 3, 2021

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: $155.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company stands on their original review. Below is an explanation from our bill review vendor. Recommend Denial – until further evaluation has been conducted. This script has been identified as a formulary medication per the ODG; however, it is recommended to evaluate the medication for injury relatedness prior to approving."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 11, 2021	Oral medication	$155.93	$127.04

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 §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §134.530 sets out the requirements for prior authorization and retrospective review.
4. The insurance carrier denied the disputed service with the following adjustment codes:
    - 197 – Payment denied/reduced for absence of precertification/authorization

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the insurance carriers' position supported?
2. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed March 11, 2021. The insurance carrier denied based on lack of prior authorization. The respondent states in their position statement stated the denial was based on a further review to establish relatedness was required.

   28 TAC §134.530 (g) (2) states in pertinent part in order for an insurance carrier to deny payment subject to retrospective review, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017.

   Review of the submitted documentation found insufficient evidence to support a retrospective review of the prescribed medication.

   28 TAC §134.530 (b) (1) (A) states in pertinent part prior authorization is required only for drugs listed as a "N" drug in the ODG Treat Formulary / Appendix A.

   Review of Appendix A found the medication in dispute is not listed as a "N" drug. The insurance carriers' denial and position statement are not supported. The service in dispute 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
Cyclobenzaprine	52817033050	G	1.64	60	$127.04	$155.93	$127.04

The total reimbursement is $127.04. 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 $127.04.

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 $127.04, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 6, 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 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.