

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

 Memorial Compounding  
RX

**Respondent Name**

Amguard Insurance Co

**MFDR Tracking Number**

M4-21-2234-01

**Carrier's Austin Representative**

Box Number 12

**DWC Date Received**

August 4, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 4, 2021	Diclofenac Sodium	\$115.85	\$0.00
May 4, 2021	Cyclobenzaprine	\$82.11	\$34.76
<b>Total</b>		\$197.96	\$34.76

### Requestor's Position

There was no related compensability, extent of injury, or liability dispute under Labor Code 410 filed timely.

**Amount in Dispute:** \$197.96

### Respondent's Position

The Austin carrier representative for Amguard Insurance Co is Shanley Price LLP. The representative was notified of this medical fee dispute on August 10, 2021.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available.

## **Findings and Decision**

### Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 TAC §137.100 sets out the administrative process for retrospective review.
2. 28 TAC §19.2003 defines retrospective review.
3. 28 TAC §19.2015 sets out the requirements for notification of utilization review.
4. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
5. 28 TAC §134.530 sets out the requirements for prior authorization of pharmacy services.
6. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

### Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- PS2 – NDC Charge(s) have been denied and no payment is recommended per script advisor clinical and formulary-based review.

### Issues

1. Is the insurance carrier's denial supported?
2. Did the requestor support compliance with applicable DWC rules?
3. What rule(s) apply to disputed services?

### **Findings**

1. The requestor is seeking reimbursement for oral medication dispensed in May of 2021. The insurance carrier denied the services as PS2 – NDC charges(s) have been denied and not payment is recommended per Script Advisor clinical and formulary-based review. DWC Rule 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states: "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

Retrospective review is defined in 28 TAC §19.2003 (28) as “The process of reviewing health care which has been provided to the injured employee under the Texas Workers’ Compensation Act to determine if the health care was medically reasonable and necessary.”

DWC Rule 28 TAC §19.2015(b) titled Retrospective Review of Medical Necessity states: (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers).”

The division finds that the carrier failed to follow the appropriate administrative process to denying the services in dispute.

- The requestor submitted a claim for Diclofenac Sodium. DWC Rule 28 TAC 134.530 states in pertinent part preauthorization is required for drugs identified with a status of “N” in the current edition of the ODG Treatment in Workers’ Comp (ODG) Appendix A. Review of the May 2021 Appendix A found:

Drug Class	Generic Name	Brand Name	Gener Equiv	Status
NSAIDs	Diclofenac sodium	Dyloject	No	N
NSAIDs	Diclofenac sodium	Voltaren ®	Yes	Y

Insufficient evidence was submitted to support the medication in dispute did not require prior authorization or that prior authorization was received. Reimbursement is not recommended.

- The remaining medication in dispute is Cyclobenzaprine and the applicable fee guideline is as follows.

DWC Rule 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:  $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \$4.00$  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	15	\$34.76	\$82.11	\$34.76

The total reimbursement is \$34.76. This amount is recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of \$34.76 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is [not] entitled to additional reimbursement for the disputed services. It is ordered that Amguard Insurance Co must remit to Memorial Compounding RX \$34.76 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

### Authorized Signature

_____	_____	October 11, 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).