Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-22-0090-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 17, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 17, 2021	69097-0158-15	$152.55	$0.00
June 17, 2021	62175-0118-43	$259.90	$257.00
	Total	$412.45	$257.00

Requestor's Position

The carrier denied the reconsideration based on lack of preauthorization. These medications do not require preauthorization therefore do not need a retrospective review.

Amount in Dispute: $412.45

Respondent's Position

Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed.

Response Submitted by: Gallagher Bassett

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.530 sets out the requirements of prior authorization for pharmacy services.
3. 28 TAC §19.2003 defines utilization review.
4. 28 TAC §19.2015 sets out the requirements of utilization review.
5. 28 TAC §134.503 sets out the fee guidelines for oral medications.

Denial Reasons

The insurance carrier denied the disputed services with the following denial codes.

- 197 – Payment denied/reduced for absence of precertification/authorization
- 5725 – First Script has denied the line for Utilization.

Issues

1. Was authorization of the disputed service required?
2. Did the insurance carrier support utilization review?
3. What rule(s) apply to disputed services?

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in June 2021. The insurance carrier denied the medication Meloxicam based on lack of prior authorization. 28 TAC §134.530 (b)(1) states in pertinent part preauthorization is only required for drugs identified with a status of "N" in the current edition of Appendix A Workers Compensation Drug Formulary. Review of the applicable Appendix A found.

Drug Class	Generic Name	Brand Name	Gener Equiv	Status
NSAIDs	Meloxicam	Mobic ®	Yes	Y
NSAIDs	Meloxicam	Vivlodex ®	No	N

   Review of the submitted documentation found insufficient documentation to support the medication dispensed was one that did not require prior authorization. The insurance carrier's denial is supported.

2. The medication Omeprazole states utilization review denied the medication. 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 address the assertions of utilization review. The disputed medication will be reviewed per applicable fee guideline.

3. DWC Rule 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	3.37	60	$257.00	$259.90	$257.00
						$259.90	$257.00

The total reimbursement is $257.00. 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 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 Safety National Casualty Corp must remit to Memorial Compounding Pharmacy $257.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 4, 2022 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. 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.

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 electronico CompConnection@tdi.texas.gov.