



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

North River Insurance Co

MFDR Tracking Number

M4-22-1029-01

Carrier's Austin Representative

Box Number 53

DWC Date Received

January 31, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 11, 2021	52817-0332-00	\$72.78	\$23.10
Total		\$72.78	\$23.10

Requestor's Position

"After reviewing the explanation of benefits, it indicates that the carrier paid \$53.90 and not the full amount of \$116.30. This claim should be processed with the full amount billed as per Administrative Labor Code 134.503 (c)."

Amount in Dispute: \$72.78

Respondent's Position

"Our bill audit company stands on their original review."

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 for prior authorization of pharmacy services.
3. 28 TAC §134.503 sets out the fee guidelines for oral medications.

Denial Reasons

The insurance carrier denied the disputed services with the following claim adjustment codes:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 197 – Payment denied/reduced for absence of precertification/authorization
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 4282 – Drugs identified with a status of "Y" in the current edition of the "Official Disability Guidelines Treatment in Workers' Comp (ODG/Appendix A, "ODG Workers'

Issues

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

Findings

1. The requestor is seeking reimbursement for the oral medication Cyclobenzaprine for date of service November 11, 2021. The submitted explanation of benefits denies the claim for lack of preauthorization.

DWC Rule 28 Texas Administrative Code §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 the ODG Treatment in Workers Comp (ODG) / Appendix A, ODG Workers Compensation Drug Formulary, and any updates.

Review of the applicable Appendix A found the disputed drug is not indicated as a "N" drug. The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. DWC Rule 28 Texas Administrative Code §134.503 (c)(1)(A)(B) states in pertinent part (c) The

insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) 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:

(A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \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	52817-0332-00	G	\$1.09	14	\$23.10	\$72.78	\$23.10
						Total	\$23.10

The total reimbursement is \$23.10. 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 entitled to additional reimbursement for the disputed services. It is ordered that North River Insurance Co must remit to Memorial Compounding RX \$23.10 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

Date

May 23, 2022

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 electrónico CompConnection@tdi.texas.gov.