



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

MEMORIAL COMPOUNDING RX

Respondent Name

NORTH RIVER INSURANCE COMPANY

MFDR Tracking Number

M4-22-1361-01

Carrier's Austin Representative

Box Number 53

DWC Date Received

March 4, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 22, 2021	Prescribed Medication	\$197.67	\$98.83
	Total	\$197.67	\$98.83

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... A list both Y and N status drugs. See attached list for review. The service billed has a Y code therefore does not require preauthorization."

Amount in Dispute: \$197.67

Respondent's Position

"Our bill audit company stands on their original review. Below is an explanation from our bill review vendor. After researching findings indicate denial for DOS 11/22/2021 medications: 1) CYCLOBENZAPRNE 10 MG TAB and 2) GABAPENTIN 300 MG CAPSULE is correct, this bill was Denied... PRIOR AUTHORIZATION/PRIOR AUTHORIZATION REQUEST RESOLUTUION COMPLETED."

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).

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.

Denial Reasons

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

- 5721 - TO AVOID DUPLICATE BILL DENIAL FOR ALL RECONSIDERATIONS/ ADJUSTMENTS/ ADDITIONAL PAYMENT REQUESTS SUBMIT A COPY OF THIS EOR...
- 90438 & 197 - PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/ AUTHORIZATION.
- 5725 - First Script has denied the line for Utilization.

Issues

1. Is the insurance carrier's denial reason supported?
2. What rules apply to disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for prescribed medication dispensed on November 22, 2021. The insurance carrier denied the prescription in dispute with denial reduction codes indicated above.

Per 28 TAC §134.530 (b)(1)(a), "(b) Preauthorization for claims subject to the Division's closed formulary. (1) Preauthorization is only required for: (a) 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..."

The DWC reviewed the divisions website to determine if the prescription indicated above required preauthorization. The following was identified:

DRUG	Appendix A, <i>ODG Workers' Compensation Drug Formulary</i>
CYCLOBENZAPRINE 10 MG	Y
GABAPENTIN 300 MG	Y

The DWC finds that preauthorization was not required for the prescriptions in dispute. As a result, the requestor is entitled to reimbursement for the prescriptions indicated above.

2. The service in dispute will be reviewed per applicable fee guideline. 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 \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	AWP	Billed Amount	Lesser of AWP and Billed Amount
CYCLOBENZAPRINE 10 MG	52817033200	G	\$1.09/30	\$44.93	\$90.25	\$44.93
GABAPENTIN 300 MG	67877022305	G	\$1.33/30	\$53.90	\$97.42	\$53.90
TOTAL				\$98.83	\$187.67	\$98.83

3. The DWC finds that the Requestor is therefore entitled to reimbursement in the amount of \$98.83, therefore this amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is due. As a result, the amount ordered is \$98.83.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester the amount of \$98.83 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

May 6, 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 512-804-4812.