TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MEMORIAL COMPOUNDING RX

Respondent Name
SENTINEL INSURANCE COMPANY

MFDR Tracking Number
M4-22-2102-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
May 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2022	Prescribed Medication	$319.45	$188.86
	Total	$319.45	$188.86

Requestor's Position

"The original claim was denied on 04/27/2022 based on (CLAIM NOT PROCESSED). An appeal was submitted on 05/12/2022. See attached 2 denials for processing. In addition, the explanation of benefits states that (EXTENT OF INJURY), is the new denial reason. There were not any additional code changes or services rendered. Therefore, the carrier cannot change from the original denial. As a provider you have to be able to address the bill properly for continue care."

Amount in Dispute: $319.45

Respondent's Position

"Please accept this letter as a response to the above dispute, The original bill was process and denied through Express Scripts on 4/27/22. We will uphold the denial per the adjuster. There are certain medications that need UR to approve."

Response Submitted by: The Hartford

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:

- 27 – Expenses incurred after coverage terminated.
- A5 – Claim not processed.
- 19 – Missing/invalid day supply
- 75 – Prior authorization required

Issues

1. Is the insurance carrier's denial reason supported?
2. Do the medications in dispute require preauthorization?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for prescribed medication dispensed on April 27, 2022. The insurance carrier states, "We will uphold the denial per the adjuster**.** There are certain medications that need UR to approve."

   28 TAC 133.307 (2)(H) states, "(2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records… (H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements).

   The insurance carrier did not submit documentation to support the denial of the claim as indicated on the EOBs. No copies of a PLN were provided for review to support their position. As a result, due to the insufficient documentation the DWC will proceed with the audit of the disputed charges.

2. The service in dispute was denied by the insurance carrier due to lack of preauthorization.

   28 TAC §134.530(b)(1)(A) states in pertinent part preauthorization is required for drugs

identified with a status of "N" in the current edition of Appendix A, ODG Workers' Compensation Drug Formulary.

Review of Appendix A found the following: The DWC finds that the drugs in question are not identified with a status of "N" in the applicable edition of the ODG, Appendix A.

Review of the ODG, Appendix A for April 2022 finds that the medications in dispute, are all indicated as "Y" drugs. Therefore, these drugs do not require preauthorization.

The DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is not supported.

3. 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)	Quantity	AWP /unit	DWC Fee	Billed Amount	Lesser of DWC Fee and Billed Amount
8 HR Muscle Ache-Pain ER 650 mg	7000030601	G	90	0.09790	$15.01	$71.78	$15.01
Gabapentin 100 mg	69097081307	G	30	0.53240	$23.97	$73.47	$23.97
Diclofenac Sodium Gel	21922000909	G	200	0.58350	$149.88	$174.20	$149.88
				TOTAL	$188.86	$319.45	$188.86

The DWC finds that the requestor, is entitled to reimbursement, in the amount of $188.86.

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 $188.86.

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 $188.86 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 22, 2022
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. 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.