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
League Pharmacy

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-22-2148-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
June 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 28, 2022	HE75	$763.02	$763.01
January 28, 2022	HEOL	$716.96	$0.00
January 28, 2022		$249.59	$249.59
January 28, 2022		$309.00	$263.60
		$2,038.57	$1,276.20

Requestor's Position

Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

Amount in Dispute: $2,038.57

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America s Downs Stanford PC. The representative was notified of this medical fee dispute on June 7, 2022.

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 §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.530 sets out the requirements of prior authorization.

3. 28 TAC §134.503 sets out the fee guidelines for pharmacy services.

Denial Reasons

- 75 – Prior Authorization required to process this bill.
- HE0L – Processed online through the Pharmacy Benefit Manager.

Issues

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

Findings

1. The requestor is seeking reimbursement for oral medication dispensed in January 2022. The oral medication Omeprazole and Meloxicam were adjudicated by the carrier and denied for lack of prior authorization. DWC Rule 28 TAC §134.530 (b) (1) states in pertinent part prior authorization 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. Review of Appendix A found for Meloxicam the brand name "Mobic" is listed as a "Y" drug. The brand name "Vivlodex" is listed as a N drug. Insufficient information such as a dispensing label was included with the documents submitted with the request for MFDR to support which brand of Meloxicam was dispensed. The insurance company's denial for Meloxicam is supported.

   Review of Appendix A for the medication Omeprazole found this medication is listed as a Y drug. The insurance carrier's denial is not supported. The service in dispute will be reviewed per applicable fee guideline.

   The requestor also seeks reimbursement for Cyclobenzaprine and Diclofenac Gel 1%. Insufficient evidence was found to support the insurance carrier adjudicated these services. These services 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: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

      (B) Brand name drugs: ((AWP per unit) x (number of units) x 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
Omeprazole	62175011843	G	3.37	180	$763.01	$763.02	$763.01
Cyclobenzaprine	52817033200	G	1.09	180	$249.59	$249.59	$249.59
Diclofenac Gel 1%	45802016000	G	0.519	400	$263.60	$309.00	$263.60
						$1,321.61	$1,276.20

The total reimbursement is $1,276.20. 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 Indemnity Insurance Co of North America must remit to League Pharmacy $1,276.20 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	August 29, 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.