



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Memorial Compounding Pharmacy

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-18-3152-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

April 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization or preauthorization was absent. These medication due not require preauthorization."

Amount in Dispute: \$382.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has submitted the medical bill in dispute for review and payment. The Carrier will forward a copy of the payment information once the payment is processed."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 28, 2017, Omeprazole DR, Zolpidem Tartrate, \$382.77, \$334.88

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 197 - "Precertification/authorization/notification absent"

Issues

1. Is the insurance carrier’s reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor is seeking reimbursement of \$382.77 for medications dispensed on June 28, 2017. The insurance carrier denied the disputed medication with claim adjustment reason code 197 – “Precertification/authorization/notification absent.”

For the dates of service in dispute the applicable rule is 28 TAC §134.530(b)(2) which states that 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;
- any compound that contains a drug 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; and
- any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

DWC finds that the medication rendered on the date of service is not identified with a status of “N” in the current edition of the ODG, *Appendix A*. Therefore, DWC concludes that the medication in question did not require preauthorization and the insurance carrier’s denial of payment for this reason is not supported. Therefore, the disputed medications will be reviewed for reimbursement.

2. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and 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;
 - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or

Ingredient	NDC	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Zolpidem Tartrate	13668000705	\$4.63	30	\$173.63	\$196.26	\$173.63
Omeprazole	68462039610	\$4.30	30	\$161.25	\$186.51	\$161.25
					\$382.77	\$334.88

The total reimbursement is \$334.88. This amount is recommended.

Conclusion

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$334.88.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services. DWC hereby ORDERS the respondent to remit to the requestor \$334.88, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	October 3, 2018
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.