



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Wellness Pharmacy

Respondent Name

Indemnity Insurance Co. of North America

MFDR Tracking Number

M4-24-1795-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

April 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 14, 2023	Meloxicam 7.5mg NDC: 29300-0124-10	\$152.56	\$122.83

Requestor's Position

"The carrier denied the original bill as well as the reconsideration based on (LACK OF PREAUTHORIZATION). Memorial did not receive any additional denial codes for the rejection of this bill from the carrier."

Amount in Dispute: \$152.56

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co. of North America is Downs Stanford, PC. The representative was notified of this medical fee dispute on April 23, 2024. 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 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.
3. [28 TAC §133.240](#) sets out guidelines for medical bill processing and audits by insurance carriers.
4. [28 TAC §§134.530](#) and [134.540](#) set out the preauthorization requirements for pharmaceutical services.
5. [TAC §19.2009](#) sets out guidelines for notice of determinations made in Utilization Review.
6. [TAC §19.2010](#) sets out guidelines for utilization reviews for health care provided and requirements prior to issuing adverse determinations.

Denial Reasons

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

- 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
- 5725 - FIRST SCRIPT HAS DENIED THE LINE FOR UTILIZATION.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 5283 - Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.

Issues

1. Is the insurance carrier's denial of payment based on lack of preauthorization supported?
2. Is the insurance carrier's denial of payment based on utilization supported?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is seeking reimbursement for Meloxicam 7.5mg x 30 units, dispensed on September 14, 2023.

Submitted documentation indicates that the insurance carrier denied the disputed drug indicating absence of preauthorization. Per 28 TAC §134.530 (b)(1) and §134.540 (b), preauthorization is only required for:

- drugs identified with a status of "N" in the current edition of the ODG Appendix A;
- any compound prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A;
- any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
- any investigational or experimental drug.

DWC finds that the drug in question was not identified with a status of "N" in the applicable edition of the ODG, *Appendix A* for the date of service reviewed in this dispute. Therefore, this drug did not require preauthorization for this reason.

The submitted documentation does not support that the disputed drug was a compound. Therefore, this drug did not require preauthorization for this reason.

The submitted documentation does not support that the disputed drug was experimental or investigational. Therefore, this drug did not require preauthorization for this reason.

DWC concludes that the insurance carrier's payment denial of the disputed drug based on absence of preauthorization is not supported for the date of service in question.

2. The insurance carrier denied reimbursement of Meloxicam 7.5mg x 30 units, dispensed on September 14, 2023, based, in part, on utilization review (UR).

28 TAC §133.240(q) states that the insurance carrier is required to comply with 28 TAC §19.2009 (relating to Notice of Determinations Made in Utilization Review) and 19.2010 (relating to Requirements Prior to Issuing Adverse Determination) when denying payment based on an adverse determination.

A review of the submitted documentation finds no evidence to support that a utilization review was performed prior to issuing a denial based on an adverse determination of utilization review.

Because the insurance carrier did not support that a utilization review of the disputed services was performed and did not meet the requirements of TAC §19.2009 and §19.2010, DWC finds that the insurance carrier's denial reasons related to utilization review are not supported.

3. Because the insurance carrier failed to support its denial reasons for the service in this dispute, DWC finds that the requestor is entitled to reimbursement.

28 TAC §134.503(c) which applies to reimbursement of the drug in dispute, states, "(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; ...

(2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:

(A) health care provider; or (B) pharmacy processing agent..."

Using the calculation above, DWC finds the following:

Drug	NDC	Generic (G)/ Brand (B)	Price/Unit	AWP Formula	Billed Amount	Lesser of AWP and Billed Amount
Meloxicam 7.5mg x 30 units	29300-0124-10	G	\$3.16870	\$122.83	\$152.56	\$122.83

The requestor is entitled to reimbursement in the amount of \$122.83.

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 reimbursement of \$122.83 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Indemnity Insurance Co. of North America must remit to Memorial Wellness Pharmacy \$122.83 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

June 12, 2024

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 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.