TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-18-4882-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medication due not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $193.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the medical billing for date of service 01/18/18 and related evidence it was determined the charges in dispute were appropriately denied with claim adjustment reason code (50: Services not Deemed 'Medically Necessary' by the payer_ based on retrospective utilization review conducted by Leo Lombardo, M.D."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2018	Meloxicam 15 mg Tablets	$193.16	$173.58

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.
2. 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – Service not Deemed 'Medically Necessary' by payer

- P12 – Workers' Compensation State Fee Schedule Adj

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drug?

Findings

1. Memorial is seeking reimbursement for Meloxicam 15 mg tablets dispensed on January 18, 2018. ACE American Insurance Company (ACE) denied the disputed drug based on medical necessity.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding … medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding … medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

   Review of the submitted documentation finds that CorVel submitted a document on behalf of ACE dated February 12, 2018, as support for a utilization review of the disputed drug. The division concludes that the submitted documentation does not support a denial based on medical necessity because the document states, "Is the requested Meloxicam tablet Lor 15MG medically necessary and appropriate? … The patient has [injury] that is consistent with NSAID therapy. Thus, it is medically necessary."

   ACE's denial reason is therefore not sufficiently supported.

2. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The reimbursement for the drugs considered in this dispute is calculated as follows[1]:

   - Meloxicam 15 mg tablets: (4.845 x 28 x 1.25) + $4.00 = $173.58

   The total reimbursement is therefore $173.58. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $173.58.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $173.58, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	January 25, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.503(c)

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.