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
City of Austin

MFDR Tracking Number
M4-18-4985-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
August 16, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $1,165.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of the Request for Medical Fee Dispute Resolution, Careworks stands on the original denial and reconsideration for the medication due to the attached non-certified determination."

Response Submitted by: CareWorks

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2018	Hydrocodone/Acetaminophen 7.5-325 mg	$144.44	$112.67
January 26, 2018	Duloxetine HCl DR 20 mg Capsules	$757.33	$757.33
January 26, 2018	Cyclobenzaprine 5 mg Tablets	$264.21	$262.39
	Total	$1,165.98	$1,132.39

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 §133.240 sets out the procedures for payment or denial of a medical bill.
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 §134.502 sets out the procedures for pharmaceutical benefits.

5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
6. 28 Texas Administrative Code, Chapter 19 sets out the requirements for utilization review.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 197 – Payment denied/reduced for absence of precertification/preauthorization.
    - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
    - Notes: "PER RUR URA 5365 INVOICE 81899 NON CERTIFIED"
    - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is the insurance carrier's denial based on preauthorization supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drugs?

Findings

1. Memorial is seeking reimbursement for Hydrocodone/Acetaminophen 7.5-325 mg tablets, Duloxetine HCl DR 20 mg capsules, and Cyclobenzaprine 5 mg tablets dispensed on January 26, 2018. The insurance carrier denied the disputed drugs based on medical necessity as determined by peer review.

    Medical necessity disputes must be resolved prior to submission of a medical fee dispute.[1] The insurance carrier is required to perform a utilization review before a denial based on medical necessity, including giving the health care provider – in this case, Memorial – an opportunity to discuss the treatment in question.[2]

    CareWorks submitted a document on behalf of City of Austin, dated February 19, 2018, to support its denial of the disputed drugs. The Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that the submitted document does not support that City of Austin performed a utilization review for the bill in question, as sufficient evidence that Memorial was given an opportunity to discuss the compound prior to the insurance carrier's denial based on medical necessity.[3]

    The DWC concludes that this dispute is not subject to dismissal based on medical necessity.

2. The insurance carrier also denied the disputed drugs based on preauthorization. Preauthorization is only required for:

    - drugs identified with a status of "N" in the current edition of the ODG Appendix A[4];
    - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A; and
    - any investigational or experimental drug.[5]

    The drugs in question are not identified with a status of "N" in the current edition of the ODG, Appendix A.

    The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review.[6] The insurance carrier provided no evidence that it engaged in a prospective or retrospective utilization review to establish that the specific drugs considered in this review are investigational or experimental.

    The insurance carrier's preauthorization denial is therefore not supported.

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[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q)
[3] 28 Texas Administrative Code §19.2009(b)
[4] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[5] 28 Texas Administrative Code §134.540(b)
[6] Texas Insurance Code §19.2005(b)

3. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement. The reimbursement is calculated as follows[7]:

    - Hydrocodone/Acetaminophen 7.5-325 mg tablets: (0.72445 x 120 x 1.25) + $4.00 = $112.67
    - Duloxetine HCl DR 20 mg capsules: (6.99833 x 100 x 1.25) + $4.00 = $878.79
      Memorial is seeking $757.33 for this drug. No additional reimbursement can be recommended.
    - Cyclobenzaprine 5 mg tablets: (1.7226 x 120 x 1.25) + $4.00 = $262.39

    The total allowable reimbursement amount is $1,132.39. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,132.39.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The division hereby ORDERS the respondent to remit to the requestor $1,132.39, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Laurie Garnes	November 1, 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.

[7] 28 Texas Administrative Code §134.503(c)