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
New Hampshire Insurance Company

MFDR Tracking Number
M4-19-0538-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 1, 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: $90.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue of medical necessity has been joined, and the disputed services have not yet been determined to be medically necessary and appropriate."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2018	Cyclobenzaprine 10 mg Tablets	$90.26	$44.95

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 reimbursement or denial of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical benefits.
4. The insurance carrier denied payment for the disputed drug based on medical necessity.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. Memorial Compounding Pharmacy is seeking reimbursement for Cyclobenzaprine 10 mg tablets dispensed on January 30, 2018. On its explanation of benefits dated March 2, 2018, the insurance carrier denied this drug based on medical necessity.

   The insurance carrier is required to submit the documentation to support an adverse determination when a service is denied for medical necessity.[1] The insurance carrier submitted utilization reviews dated November 16, 2017, and January 22, 2018, to support its denial of the drug in question.

   The submitted utilization reviews do not address medical necessity for Cyclobenzaprine 10 mg tablets, the only drug considered in this dispute. No evidence was provided to support that a utilization review for medical necessity was performed for Cyclobenzaprine 10 mg tablets. The division concludes that the insurance carrier's reason for its denial of this drug is not supported.

2. Because the insurance carrier failed to support its denial of payment for Cyclobenzaprine 10 mg tablets, Memorial is entitled to reimbursement for this drug.

   The reimbursement for the drug considered in this dispute is calculated as follows[2]:

   - Cyclobenzaprine 10 mg tablets: (1.092 x 30 x 1.25) + $4.00 = $44.95

   The total reimbursement is therefore $44.95. 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 $44.95.

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 $44.95, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	March 20, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.307(I)
[2] 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.