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
M4-19-0603-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 3, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The service billed has a Y code therefore does not require preauthorization."

Amount in Dispute: $293.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor did not request and receive preauthorization for this investigational or experimental compound formulation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2018	Meloxicam 15 mg tablets	$202.85	$185.69
January 30, 2018	Cyclobenzaprine 10 mg tablets	$90.26	$44.95
	Total	$293.11	$230.64

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 §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

- HE75 – Prior Authorization required to process this bill.

Issues

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

Findings

1. Memorial is seeking reimbursement for Meloxicam 15 mg tablets and Cyclobenzaprine 10 mg tablets dispensed on January 30, 2018. The insurance carrier denied the disputed compound based on preauthorization. Preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A[1];
   - 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.[2]

   The Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that the drugs in question are identified with a status of "Y" in the current edition of the ODG Appendix A.

   Flahive, Ogden & Latson, on behalf of the insurance carrier, argued that "The requestor did not request and receive preauthorization for this investigational or experimental compound formulation."

   The DWC finds no evidence to suggest that the drugs in question are part of a compound formulation or that the drugs are investigational or experimental. The insurance carrier's preauthorization denial is therefore not supported.

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

   The reimbursement for the drugs considered in this dispute is calculated as follows[3]:

   - Meloxicam 16 mg tablets: (4.845 x 30 x 1.25) + $4.00 = $185.69
   - Cyclobenzaprine 10 mg tablets: (1.092 x 30 x 1.25) + $4.00 = $44.95

   The total reimbursement is therefore $230.64. 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 $230.64.

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 $230.64, 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 19, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

[1] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*

[2] 28 Texas Administrative Code §134.540(b)

[3] 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.