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
ABF Freight System Inc

MFDR Tracking Number
M4-19-1551-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
November 16, 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: $344.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier's Austin representative acknowledged receipt of the copy of this medical fee dispute on November 26, 2018. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. If a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.[1]

No response has been received on behalf of ABF Freight System Inc to date. For that reason, the decision will be based on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2018	Gabapentin 400 mg Capsules	$153.22	$123.65
May 4, 2018	Acetaminophen/Codeine #4 Tablets	$90.61	$45.39
May 4, 2018	Methocarbamol 750 mg Tablets	$101.06	$58.45
	Total	$344.89	$227.49

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.

[1] 28 Texas Administrative Code §133.307(d)(1)

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 benefits.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Note: "OUTSIDE RETROACTIVE REVIEW HAS DETERMINED THAT THIS SERVICE WAS NOT MEDICALLY REASONABLE & NECESSARY AT THIS TIME FOR THIS WORK INJURY. NOT COMPENSABLE UNDER TX WORKERS' COMPENSATION. PLEASE CREDIT THIS ACCOUNT. THANK YOU."
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is this dispute subject to dismissal based on compensability?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. Memorial Compounding Pharmacy is seeking reimbursement for drugs dispensed on May 4, 2018. On its explanations of benefits dated June 4, 2018, and October 18, 2018, the insurance carrier denied these drugs 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.[2] The submitted documentation does not include a utilization review denying medical necessity for the drugs in question.

   Due to a lack of supporting documentation, the division finds that this dispute is not subject to dismissal based on medical necessity.

2. The insurance carrier also denied the disputed drugs based on the compensability of the injury. A dispute regarding compensability must be resolved prior to a request for medical fee dispute.[3]

   The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves extent of injury. Review of the submitted documentation finds that ABF Freight System Inc failed to provide a copy of a related PLN to the division to support a denial based on extent of injury.

   Therefore, the dispute considered here is not subject to dismissal based on this denial reason.

3. Because the insurance carrier failed to support its denial of payment for the drugs in question, Memorial is entitled to reimbursement for these drugs.

   The reimbursement for the drugs considered in this dispute is calculated as follows[4]:

   - Gabapentin 400 mg capsules: (1.5953 x 60 x 1.25) + $4.00 = $123.65
   - Acetaminophen/Codeine #4 tablets: (0.55186 x 60 x 1.25) + $4.00 = $45.39
   - Methocarbamol 750 mg tablets: (0.726 x 60 x 1.25) + $4.00 = $58.45

   The total reimbursement is therefore $227.49. 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 $227.49.

[2] 28 Texas Administrative Code §133.307(d)(2)(I)
[3] 28 Texas Administrative Codes § 133.307(d)(2)(H)
[4] 28 Texas Administrative Code §134.503(c)

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 $227.49, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	April 11, 2019
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.