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
American Home Assurance Company

MFDR Tracking Number
M4-19-1948-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on **PARTIAL PAYMENT**. It looks like the carrier processed and paid only PARTIAL of the total bill."

Amount in Dispute: $361.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier certified the retrospective request for tramadol, but paid at half the requested rate, based on the fee schedule."

Response Submitted by: Hoffman Kelley Lopez LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2018	Tramadol HCl ER 300 mg tablets	$361.73	$361.73

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 reduced payment for the disputed services with the following claim adjustment codes:
    - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
    - 5059 – Based on the diagnosis, treatment patterns and/or number of visits. The treatment exceeds our physician parameters. Refer to the doctor report.
    - 6611 – Reviewed by RSL.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to reimbursement for the drug in question?

Findings

1. Memorial Compounding Pharmacy is seeking reimbursement for Tramadol HCl ER 300 mg tablets dispensed on May 7, 2018. On its explanation of benefits dated June 6, 2018, the insurance carrier denied this drug based on medical necessity.

   The insurance carrier is required to submit the documentation of documentation to support an adverse determination when a service is denied for medical necessity. The submitted documentation does not include a utilization review denying medical necessity for the drug in question. In its position statement, Hoffman Kelley Lopez LLP, on behalf of American Home Assurance Company, stated that Tramadol was certified.

   The division finds that the insurance carrier's reason for denial is not supported.

2. Because the insurance carrier failed to support its denial, Memorial is entitled to reimbursement for the drug in question. In its position statement, Hoffman Kelley Lopez LLP stated that half of the billed amount for Tramadol HCl ER 300 mg tablets was paid. No explanations of benefits were submitted indicating payment for the disputed drug. The division concludes that no reimbursement was made for this drug.

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

   - Tramadol HCl ER 300 mg tablets: (10.141 x 30 x 1.25) + $4.00 = $384.29

   The total reimbursement is therefore $384.29. Memorial is seeking $361.73. 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 $361.73.

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 $361.73, 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 13, 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.