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
M4-19-2278-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 20, 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: $365.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains provider is not entitled to reimbursement based upon peer review."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2018	Cyclobenzaprine 5 mg Tablets	$160.86	$133.20
June 13, 2018	Tramadol HCl 50 mg Tablets	$132.46	$97.70
June 13, 2018	Ibuprofen 600 mg Tablets	$71.92	$19.72
	Total	$365.24	$250.62

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 §134.503 sets out the fee guidelines for pharmaceutical services.
5. Texas Insurance Code, Chapter 19 sets out the requirements for utilization review.

6. The insurance carrier reduced payment for the disputed drug based on medical necessity.

Issues

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

Findings

1. Memorial is seeking reimbursement for drugs dispensed on June 13, 2018. In its position statement, ESIS, on behalf of the insurance carrier, argued that this dispute involved an extent of injury issue.

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.[1]

   The submitted documentation does not support that a denial based on the extent of the compensable injury was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Per explanation of benefits dated July 11, 2018, the insurance carrier denied the disputed drug based on medical necessity.

   If a dispute regarding medical necessity exists, the medical necessity dispute must be resolved prior to a request for medical fee dispute resolution.[2] A medical necessity denial of a medical bill must be based on an adverse determination by a utilization review agent.[3]

   The submitted documentation includes a report dated May 12, 2016, as support for utilization review of the disputed compound. This report does not support that the insurance carrier performed a utilization review of the compound in question for the following reasons[4]:

   - The document does not include a description for filing a complaint with the Texas Department of Insurance,
   - The document does not include information describing the processes for filing an appeal,
   - The document itself states, "Med*Confirm* has no authority to approve or deny authorization or reimbursement for health care on behalf of the insurance carrier. Accordingly, this opinion does not constitute a determination for the purposes of utilization review. Before any health care addressed above may be approved or denied based on the grounds of medical necessity or appropriateness or care, a formal utilization review and determination by a utilization review agent with the authority to act on your behalf must be conducted."

   For these reasons, the insurance carrier's denial is not sufficiently supported. This dispute is not subject to dismissal based on medical necessity.

3. Because the insurance carrier failed to support its denial, Memorial is entitled to reimbursement for the drugs in question. The calculation of the total allowable amount is as follows:

   - Cyclobenzaprine 5 mg tablets: (1.7226 x 60 x 1.25) + $4.00 = $133.20
   - Tramadol HCl 50 mg tablets: (0.83289 x 60 x 1.25) + $4.00 = $97.70

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] 28 Texas Administrative Code §133.305(b)
[3] 28 Texas Administrative Code §133.240(q), 28 Texas Administrative Codes §§19.2009 and 19.2010
[4] 28 Texas Administrative Code §19.2009(b)

- Ibuprofen 600 mg tablets: (0.2403 x 60 x 1.25) + $4.00 = $19.72

The total allowable amount is $250.62. 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 $250.62.

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 $250.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	July 23, 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.