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
M4-19-2583-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

Amount in Dispute: $325.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier understands the PBM paid the amitriptyline in bulk check no. 2205325, in accordance with the PBM contract … The Requestor did not request and receive preauthorization for these drug forms that are not included in Division's Closed Formulary."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2018	Tizanidine HCl 4 mg Tablets	$145.41	$113.89
September 9, 2018	Amitriptyline HCl 25 mg Tablets	$75.60	$0.00
September 9, 2018	Hydrocodone/APAP 10/325 Tablets	$104.35	$62.56
	Total	$325.36	$176.45

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 Amitriptyline based on fee guidelines.
5. The insurance carrier denied payment for the disputed Tizanidine and Hydrocodone/APAP based on medical necessity.

Issues

1. Is the insurance carrier's denial of payment for the disputed Tizanidine HCl 4 mg tablets and Hydrocodone/APAP 10/325 tablets?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement for the disputed Amitriptyline HCl 25 mg tablets?
3. Is Memorial entitled to reimbursement for the disputed Tizanidine HCl 4 mg tablets and Hydrocodone/APAP 10/325 tablets?

Findings

1. Memorial Compounding Pharmacy is seeking reimbursement for Tizanidine HCl 4 mg tablets and Hydrocodone/APAP 10/325 tablets dispensed on September 6, 2018. On its explanation of benefits dated December 7, 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.[1] The submitted documentation does not include a utilization review denying medical necessity for Tizanidine HCl 4 mg tablets and Hydrocodone/APAP 10/325 tablets in question.

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

2. Review of the explanations of benefits provided also finds that the insurance carrier issued a payment for Amitriptyline HCl 25 mg tablets in the amount of $26.63 to Memorial on December 7, 2018, via check number 2205325. The division concludes that Memorial has received payment for the drug in question.

   The carrier reduced the billed amount to a total payment of $26.63 for Amitriptyline HCl 25 mg tablets citing the workers' compensation fee schedule as its reason for the reduction. Rule at 28 Texas Administrative Code §134.503(c) applies and states, in pertinent part, that the insurance carrier shall reimburse the lesser of: (1) the fee established by the division's applicable formula based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed; or (2) the amount billed to the insurance carrier.

   Memorial is requesting reimbursement in the amount of $75.60 for Amitriptyline HCl 25 mg tablets. Memorial has the burden to support its request for this amount. In its original position statement, Memorial did not demonstrate how it arrived at the requested amount or whether that amount is consistent with the methodology under 28 TAC §134.503(c). After notification by the division's medical fee dispute resolution program of the carrier's response and payment, Memorial did not take the opportunity to refute the carrier's payment calculation for Amitriptyline HCl 25 mg tablets. For that reason, the division moves to resolve the dispute of this drug with the information available and concludes that no additional reimbursement can be recommended.

3. Because the insurance carrier failed to support its denial of payment for Tizanidine HCl 4 mg tablets and Hydrocodone/APAP 10/325 tablets, Memorial is entitled to reimbursement for the drugs in question.

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

   - Tizanidine HCl 4 mg tablets: (1.46524 x 60 x 1.25) + $4.00 = $113.89
   - Hydrocodone/APAP 10/325 tablets: (0.78082 x 60 x 1.25) + = $62.56

   The total reimbursement is therefore $176.45. This amount is recommended.

[1] 28 Texas Administrative Code §133.307(I)
[2] 28 Texas Administrative Code §134.503(c)

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 $176.45.

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 $176.45, 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

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.