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
M4-19-2872-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 24, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $330.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The reviewer, Dmitry Golovko, M.D., MPH reviewed these same prescriptions for date of service 05/04/18 and found they were not medically necessary or appropriate."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2018	Acetaminophen/Codeine #4 Tablets	$90.61	$0.00
June 6, 2018	Methocarbamol 500 mg Tablets	$86.45	$40.19
June 6, 2018	Gabapentin 400 mg Capsules	$153.89	$0.00
	Total	$330.95	$40.19

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 §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Issues

1. Is the insurance carrier's denial of payment based on medical necessity supported?
2. Is the requestor entitled to reimbursement for this dispute?

Findings

1. Memorial is seeking reimbursement for:

    - Acetaminophen/Codeine #4 Tablets
    - Methocarbamol 500 mg Tablets
    - Gabapentin 400 mg Capsules

    The insurance carrier denied the drugs in question based on medical necessity. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

    The submitted documentation includes a utilization review with an adverse determination for

    - Acetaminophen/Codeine Tablets
    - Methocarbamol 750 mg Tablets
    - Gabapentin 400 mg Capsules

    The division finds that the disputed services contain unresolved issues of medical necessity for Acetaminophen/Codeine Tablets and Gabapentin 400 mg Capsules which are included in this medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

    The division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives***.

    The documentation submitted does not include a utilization review was performed for Methocarbamol 500 mg Tablets to support a denial based on an adverse determination. The insurance carrier's denial for this drug is not supported.

2. Because the insurance carrier failed to support its denial of payment for Methocarbamol 500 mg Tablets, Memorial is entitled to reimbursement for the drug in question.

    The reimbursement considered in this dispute is calculated in accordance with 28 Texas Administrative Code §134.503(c) as follows:

    - Methocarbamol 500 mg Tablets: (0.4825 x 60 x 1.25) + $4.00 = $40.19

    The total reimbursement is therefore $40.19. This amount is recommended.

Conclusion

The division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This decision and order is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. 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 $40.19.

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 $40.19, 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 18, 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.