TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-19-3148-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 15, 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: $123.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… we have escalated the bills in question for bill review audit and payment."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2018	Cyclobenzaprine 5 mg Tablets	$123.02	$85.90

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Codes §§134.530 and 134.540 set out the guidelines for preauthorization of pharmaceutical services.
4. The insurance carrier denied payment for the disputed drug based on preauthorization.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drug in question?

Findings

1. Memorial is seeking reimbursement for Cyclobenzaprine 10 mg tablets dispensed on September 20, 2018. Submitted documentation supports that the insurance carrier also denied the disputed drug based on preauthorization. Preauthorization is only required for:

    - drugs identified with a status of "N" in the current edition of the ODG Appendix A[1];
    - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A; and
    - any investigational or experimental drug.[2]

    The DWC finds that the drug in question is not identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization.[3]

    The submitted documentation does not support that the disputed drug is experimental or investigational. Therefore, this drug does not require preauthorization.[4]

    The DWC concludes that the insurance carrier's denial of payment of the disputed drug based on preauthorization is not supported.

2. Because the insurance carrier failed to support its denial of payment for the disputed drugs, Memorial is entitled to reimbursement.

    The reimbursement considered in this dispute is calculated as follows[5]:

    - Cyclobenzaprine HCl 10 mg capsules: (1.092 x 60 x 1.25) + $4.00 = $85.90

    The total reimbursement is therefore $85.90. 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 $85.90.

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 $85.90, 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

[1] *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*
[2] 28 TAC §134.530(b)(1) and §134.540(b)
[3] 28 TAC §134.530(b)(1)(A) and §134.540(b)(1)
[4] 28 TAC §134.530(b)(2)(D) and §134.540(b)(4)
[5] 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.