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
City of Houston

MFDR Tracking Number
M4-19-3551-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
March 25, 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: $334.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "If Requestor is dissatisfied with Respondents adverse determination of medical necessity, it is required to request Review by an Independent Review Organization."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2018	Gabapentin 300 mg capsules	$178.26	$154.95
October 29, 2018	Cyclobenzaprine 10 mg tablets	$155.78	$126.85
	Total	$334.04	$281.80

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 benefits.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization.
   - Notes: "Denied Per Retrospective Peer Review Determination"

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drugs?

Findings

1. Memorial Compounding Pharmacy is seeking reimbursement for medications dispensed on October 29, 2018. On its explanation of benefits dated December 14, 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 Gabapentin 300 mg capsules and Cyclobenzaprine HCl 10 mg tablets considered in this dispute.

   The division concludes that this dispute is not subject to dismissal based on medical necessity.

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

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

   - Gabapentin 300 mg capsules: (1.3418 x 90 x 1.25) + $4.00 = $154.95
   - Cyclobenzaprine HCl 10 mg tablets: (1.092 x 60 x 1.25) + = $126.85

   The total reimbursement is therefore $281.80. 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 $281.80.

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 $281.80, 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

[1] 28 Texas Administrative Code §133.307(l)
[2] 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.