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
M4-19-3649-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
April 1, 2019

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $364.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dmitry Golovko, M.D., MPH made his adverse determination and determined the medication requested was not medically necessary or appropriate."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2018	Gabapentin 400 mg Capsules	$202.09	$0.00
August 1, 2018	Ibuprofen 600 mg Tablets	$71.92	$19.72
August 1, 2018	Acetaminophen/Codeine #4 Tablets	$90.61	$0.00
	Total	$364.62	$19.72

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. The insurance carrier denied payment for the drugs in question based on medical necessity.

Issues

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

Findings

1. Memorial is seeking reimbursement for Gabapentin 400 mg capsules and Acetaminophen/Codeine #4 tablets dispensed on August 1, 2018. The insurance carrier denied payment to Memorial due to an unresolved medical necessity issue. Memorial was notified of the denial via an explanation of benefits issued in the manner and within the timeframe required by 28 Texas Administrative Code §133.240.

   Additionally, the insurance carrier presented a copy of documentation required by 28 Texas Administrative Code §133.307(d)(2)(I). Specifically, the insurance carrier supported that it conducted utilization review and presented a denial based on adverse determination for the compound in question to Memorial.

   The DWC concludes that an unresolved medical necessity issue exists for the drugs in question. Medical fee dispute resolution is not the proper venue for resolution of a medical necessity dispute.

   Memorial is hereby notified that the correct remedy for resolution of a medical necessity denial is found at 28 Texas Administrative Code §133.308 titled *MDR of Medical Necessity Disputes*.

   To initiate a request for resolution of a medical necessity denial, the health care provider should complete and file a DWC Form LHL009 titled *REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION (IRO)*. A copy of the form and the form instructions are attached.

   Memorial is also seeking reimbursement for Ibuprofen 600 mg tablets dispensed on August 1, 2018. The documentation submitted does not include a utilization review was performed for Ibuprofen 600 mg tablets to support a denial based on an adverse determination.[1]

2. Because the insurance carrier failed to support its denial of Ibuprofen 600 mg tablets, Memorial is entitled to reimbursement for this drug. The reimbursement considered in this dispute is calculated as follows[2]:

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

   The total reimbursement is therefore $19.72. 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 $19.72.

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 $19.72, 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 16, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.240(q)

[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.