MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
ACE American Insurance Co

MFDR Tracking Number
M4-19-3973-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 29, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was denied on 03/11/2019 (W-9) based on PRE-AUTHORIZATION."

Amount in Dispute: $419.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bill for date of service 02/27/19 was denied on unnecessary treatment with peer review. Carrier maintains provider is not entitled to reimbursement based upon peer review. Furthermore, per Decision & Order the compensable injury does not extend to or include right ankle internal derangement, right anterior talofibular partial tear or right tendinitis of the Achilles tendon."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2019	Acetaminophen/COD tablet	$90.61	$308.19
	Cyclobenzaprine tablet	$119.74	
	Gabapentin tablet	$208.70	

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.

3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
5. The insurance carrier denied payment based on medical necessity.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is this dispute subject to dismissal based on medical necessity?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the drugs in question?

Findings

1. Memorial is seeking reimbursement for Acetaminophen/COD, Cyclobenzaprine and Gabapentin tablets dispensed on February 27, 2019. In its position statement ESIS argued on behalf of Ace American Insurance Co that the disputed drugs were denied based on compensability. The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the division. Any new denial reasons or defenses raised shall not be considered for review.

   The submitted documentation does not support that a denial based on compensability was provided to Memorial before this request for MFDR was filed. Therefore, the division will not consider this argument in the current dispute review as this issue constitutes a new defense

2. Per explanation of benefits dated March 04, 2019, the insurance carrier denied the disputed compound based on medical necessity.

   If a dispute regarding medical necessity exists, the medical necessity dispute must be resolved prior to a request for medical fee dispute resolution. A medical necessity denial of a medical bill must be based on an adverse determination by a utilization review agent.

   The submitted documentation includes a report dated April 24, 2017, as support for utilization review of the disputed compound. This report does not support that the insurance carrier performed a utilization review of the medications in question for the following reasons :

   The document does not include a description for filing a complaint with the Texas Department of Insurance,

   The document does not include information describing the processes for filing an appeal,

   The document itself includes the statement, "In and of itself, this opinion does not constitute a recommendation for specific claims or administrative functions to be made or enforced**."**

   For these reasons, the insurance carrier's denial is not sufficiently supported. This dispute is not subject to dismissal based on medical necessity.

3. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows:

   - Acetaminophen/Codeine tablets: (0.55186 x 60 x 1.25) = $41.39
   - Cyclobenzaprine Tablets : (1.03740 x 60 x 1.25) = $77.81
   - Gabapentin Tablets: (2.52000 x 60 x 1.25) = $189.00

   The total reimbursement is therefore $308.19. 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 $308.19.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $308.19, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_______________________	_______________________	6/14/2019
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 DWC 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.