



# 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**

Hartford Insurance Co

**MFDR Tracking Number**

M4-19-4115-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

May 13, 2019

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The request was submitted and received by the carrier on 04/12/2019 via certified mail still with no response. I have attached proof of submission for both correspondences."

**Amount in Dispute:** \$328.03

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This disputes involves pharmaceutical services denied based on medical necessity. Therefore, DWC Rule 133.308 would apply, not DWC Rule 133.307."

**Response Submitted by:** Downs Stanford PC

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2019	Cyclobenzaprine Tablets	\$150.87	\$266.29
	Gabapentin Capsule	\$177.16	

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
- The insurance carrier denied payment based on the absence of preauthorization.

## Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

## Findings

1. Memorial is seeking reimbursement for a Cyclobenzaprine Tablets and Gabapentin Capsule dispensed on February 28, 2019. In its position statement the insurance carrier argued that the disputed drug was denied based on medical necessity.

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 medical necessity 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. Memorial is seeking reimbursement for the drugs dispensed on February 28, 2019. The insurance carrier denied the disputed compound based on preauthorization. Preauthorization is only required for:
  - drugs identified with a status of "N" in the current edition of the ODG Appendix A;
  - 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.

The compound in question does not contain an ingredient identified with a status of "N" in the current edition of the ODG, Appendix A.

The determination of a service's investigational or experimental nature is determined on a case by case basis through utilization review. Downs Stanford PC provided no evidence that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental.

Because the insurance carrier failed to perform utilization review on the disputed compound, the requirement for preauthorization based on a premise that the compound is investigational or experimental is not triggered in this case. The insurance carrier's preauthorization denial is therefore not supported.

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:

- Cyclobenzaprine Tablets ( $\$1.04 \times 90 \times 1.25$ ) = \$116.71
- Gabapentin Capsule ( $\$1.33 \times 90 \times 1.25$ ) = \$149.58

The total reimbursement is therefore \$266.29. 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 \$266.29.

### **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 \$266.29, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

6/21/2019  
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.**