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**
New Hampshire Insurance Company

**MFDR Tracking Number**
M4-19-4176-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
May 20, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier has received the attached bill and has not processed according to Texas Labor Code 408.027."

**Amount in Dispute:** $259.59

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier's position is shown on the attached EOB."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 5, 2019 | Cyclobenzaprine HCl 10 m | $150.87 | $120.71 |
| February 5, 2019 | Hydrocodone/Acetaminophen 10-325 Tablets | $108.72 | $68.02 |
| | Total | $259.59 | $188.73 |

## *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 drugs based on preauthorization.:

**Issues**

1. Is the insurance carrier's denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed drugs?

**Findings**

1. Memorial is seeking reimbursement for drugs dispensed February 5, 2019. In its position statement, Flahive, Ogden & Latson stated, "the Carrier is in the process of reconsidering the submission and will supplement this Response upon completion of that process." To date, no supplemental response has been received. For this reason, the DWC will review this dispute with the information available.

   Submitted documentation indicates that the insurance carrier 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 prescribed before July 1, 2018 that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A;
   - any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and
   - any investigational or experimental drug.[2]

   The DWC finds that the drugs in question are not identified with a status of "N" in the applicable edition of the ODG, *Appendix A*. Therefore, these drugs do not require preauthorization for this reason.[3]

   The submitted documentation does not support that the disputed drugs are a compound. Therefore, these drugs do not require preauthorization for this reason.[4]

   The submitted documentation does not support that the disputed drugs are experimental or investigational. Therefore, these drugs do not require preauthorization for this reason.[5]

   The DWC concludes that the insurance carrier's denial of payment of the disputed drugs 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[6]:

   - Cyclobenzaprine HCl 10 mg tablets: (1.0374 x 90 x 1.25) + $4.00 = $120.71
   - Hydrocodone/Acetaminophen 10-325 tablets: (0.85364 x 60 x 1.25) + $4.00 = $68.02

   The total reimbursement is therefore $188.73. This amount is recommended.

**Conclusion**

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $188.73.

[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)(1)(B) and (C), and §134.540(b)(2) and (3)
[5] 28 TAC §134.530(b)(1)(D) and §134.540(b)(4)
[6] 28 Texas Administrative Code §134.503(c)

## *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 $188.73, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Laurie Garnes | October 4, 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 DWC 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**.