



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MEMORIAL COMPOUNDING RX

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-20-0864-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 9, 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: \$312.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... Dr. Mittal non-certified the Meloxicam as not medically necessary, and Dr. Lamie non-certified the Diclofenac Sodium 1% gel as not medically necessary."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2019	Meloxicam 15 mg Tablets	\$202.85	\$0.00
July 23, 2019	Diclofenac Sodium 1% Gel	\$110.12	\$69.78
	Total	\$312.97	\$69.78

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 §133.240 sets out the procedures for payment or denial of medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Issues

1. Is New Hampshire Insurance Company's denial of payment supported for the drugs in question?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement?

Findings

1. Memorial is seeking reimbursement for drugs dispensed on July 23, 2019. The drugs in dispute are Meloxicam 15 mg tablets and Diclofenac Sodium 1% gel.

Per explanation of benefits dated August 5, 2019, the insurance carrier denied the drugs in question based on medical necessity. 28 TAC §133.305 (b) requires that "If a dispute regarding ... medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding ... medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021."

The submitted documentation includes a utilization review, dated July 18, 2019, with an adverse determination for Meloxicam.

The DWC finds that the dispute of Meloxicam contains unresolved issues of medical necessity. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

The DWC hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 TAC §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under **Health Care Providers or their authorized representatives**.

In its position statement on behalf of the insurance carrier, the Silvera Firm submitted a utilization review dated August 30, 2019, with an adverse determination for Diclofenac Sodium. This document was dated after the explanation of benefits presented with this dispute.

No evidence was provided to support that the insurance carrier gave the health care provider a reasonable opportunity to discuss the medical necessity of Diclofenac Sodium prior to its denial, as required by 28 TAC §133.240 (q). The insurance carrier's denial for this drug is not supported.

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

The reimbursement considered in this dispute is calculated in accordance with 28 TAC §134.503 (c) as follows:

- Diclofenac Sodium 1% Gel: $(0.5262 \times 100 \times 1.25) + \$4.00 = \$69.78$

The total reimbursement is therefore \$69.78. This amount is recommended.

Conclusion

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 \$69.78.

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 \$69.78, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Laurie Garnes

Medical Fee Dispute Resolution Officer

December 31, 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 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.