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 RX

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-20-0946-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 16, 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: $110.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider submitted billing for filling the prescribed diclofenac sodium gel. The Carrier reviewed the billing in question and denied reimbursement as no preauthorization had been requested or approved for the dispensing of the N-listed drug. As diclofenac sodium gel is not an approved drug under the closed formulary and no preauthorization had been requested, reimbursement was denied for failing to meet medical necessity standards."

Response Submitted by: Constitution State Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27, 2019	Diclofenac Sodium 1% Gel	$110.12	$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

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
2. 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
5. Texas Insurance Code, Chapter 19 sets out the requirements for utilization review.

6. 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 this dispute subject to dismissal due to an unresolved medical necessity issue?
2. Did the insurance carrier raise a new defense in its response?
3. Is Memorial Compounding Rx (Memorial) entitled to additional reimbursement?

Findings

1. Memorial is seeking reimbursement for Diclofenac Sodium 1% Gel dispensed on September 27, 2019. Per explanation of benefits dated November 7, 2019, the insurance carrier denied the disputed drug based on medical necessity.

   Medical necessity disputes must be resolved prior to submission of a medical fee dispute.[1] The insurance carrier is required to perform a utilization review before a denial based on medical necessity, including giving the health care provider – in this case, Memorial – an opportunity to discuss the treatment in question.[2]

   The respondent is required to submit documentation to support a denial based on lack of medical necessity.[3] Constitution State Services provided no evidence on behalf of the insurance carrier to support that it performed a utilization review on the drug in question to determine medical necessity.[4]

   This denial reason is not supported. Therefore, this dispute is not subject to dismissal based on medical necessity.

2. In its position statement, Constitution State Services argued that "The Carrier reviewed the billing in question and denied reimbursement as no preauthorization had been requested or approved for the dispensing of the N-listed drug."

   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 Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.[5]

   The submitted documentation does not support that a denial based on preauthorization was provided to Memorial before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

3. Because the insurance carrier failed to support its denial of payment for the disputed drug, Memorial is entitled to reimbursement.

   The reimbursement considered in this dispute is calculated as follows[6]:

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

   The total allowable reimbursement is $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.

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[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q)
[3] 28 Texas Administrative Code §133.307(d)(2)(I)
[4] 28 Texas Administrative Codes §§134.240 and 19.2009
[5] 28 Texas Administrative Code §133.307(d)(2)(F)
[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 $69.78, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	January 16, 2020
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.