



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

XL INSURANCE AMERICA INC

MFDR Tracking Number

M4-21-1108-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 3, 2021

REQUESTOR'S POSITION SUMMARY

"Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: \$155.93

RESPONDENT'S POSITION SUMMARY

"This denial response was submitted through Coventry Connect First Script module which is available for resolution manager review. Nothing in the claimants file to indicate resolution manager ... has requested to overturn this denial decision ... Recommend Denial – until further evaluation has been conducted. This script has been identified as a formulary medication per the ODG; however, it is recommended to evaluate the medication for injury relatedness prior to approving."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2020	Cyclobenzaprine 5 mg Tablets	\$155.93	\$127.04

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 §134.503 sets out the fee guidelines for pharmaceutical services.
- 28 Texas Administrative Codes §§134.530 and 134.540 set out the preauthorization requirements for pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – Payment denied/reduced for absence of precertification/authorization.
 - 5725 – First Script has denied the line for Utilization.

- 00950 – This bill is a reconsideration of a previously reviewed bill, allowance amounts reflect any changes to the previous payment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider’s contract, or car

Issues

1. Is the insurance carrier’s denial of payment based on preauthorization supported?
2. Is Memorial Compounding Rx (Memorial) entitled to reimbursement?

Findings

1. Memorial is seeking reimbursement for Cyclobenzaprine dispensed on December 10, 2020.

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 A¹;
- 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 Cyclobenzaprine is not identified with a status of “N” in the applicable edition of the ODG, *Appendix A*. Therefore, this drug does not require preauthorization for this reason.³

The submitted documentation does not support that the disputed drug is a compound. Therefore, this drug does not require preauthorization for this reason.⁴

The submitted documentation does not support that the disputed drug is experimental or investigational. Therefore, this drug does not require preauthorization for this reason.⁵

The DWC concludes that the insurance carrier’s denial of payment of the disputed drug based on preauthorization is not supported.

2. Because XL Insurance America, Inc. failed to support its denial reason for the service in this dispute, the DWC finds that Memorial is entitled to reimbursement.

The reimbursement considered in this dispute is calculated as follows⁶:

- Cyclobenzaprine 5 mg tablets: $(1.6405 \times 60 \times 1.25) + \$4.00 = \$127.04$

The total allowable reimbursement is \$127.04. 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 \$127.04.

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 TAC §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 \$127.04, 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

Date

May 13, 2021

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.