



# 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 Pharmacy

**Respondent Name**

American Zurich Insurance Company

**MFDR Tracking Number**

M4-18-4035-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 19, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These medication due not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** \$235.42

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier has confirmed that Memorial first submitted its bill to its PBM and that the bill the subject of this request was paid in full in accordance with Memorial's contract with the PBM ... on 11/29/2017."

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

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2017	Cyclobenzaprine 5 mg Tablets	\$160.86	\$133.20
October 25, 2017	Acetaminophen/Codeine #3 Tablets	\$74.56	\$25.33
Total		\$235.42	\$158.53

#### 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 §133.240 sets out the procedures for payment or denial of a medical bill.
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 §134.502 sets out the procedures for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

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.
  - P2 – Not a work related injury/illness and thus not the liability of the workers’ compensation carrier.

### **Issues**

1. Is the insurance carrier’s claim of full payment supported?
2. Is this dispute subject to dismissal based on medical necessity?
3. Is this dispute subject to dismissal based on liability?
4. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement of the drugs in question?

### **Findings**

1. Memorial is seeking reimbursement of Cyclobenzaprine 5 mg tablets and Acetaminophen/codeine #3 tablets dispensed on October 25, 2017. In its position statement, Flahive, Ogden & Latson argued on behalf of American Zurich Insurance Company (Zurich) that the charges had been paid in full.

Review of the submitted documentation does not support that any reimbursement was paid to Memorial for the drugs considered in this dispute.

2. According to the sole explanation of benefits provided with this dispute, Zurich denied the drugs, in part, based on medical necessity.

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

The Texas Department of Insurance, Division of Workers’ Compensation (DWC) finds that Flahive, Ogden & Latson failed to provide any evidence to support that the Zurich performed a utilization review addressing the drugs in question. The DWC concludes that this dispute is not subject to dismissal based on medical necessity.

3. Zurich also denied the disputed drugs, in part, based on liability. A dispute regarding the insurance carrier’s liability must be resolved prior to a request for medical fee dispute.<sup>3</sup>

The respondent is required to attach a copy of any related Plain Language Notice (PLN) if the medical fee dispute involves compensability or liability. Review of the submitted documentation finds that Flahive, Ogden & Latson failed to attach a copy of a related PLN on behalf of the insurance carrier to support a denial based on compensability.

The dispute in question is not subject to dismissal as this denial reason was not sufficiently supported.

4. Because the insurance carrier failed to support any denial of payment, Memorial is entitled to reimbursement.

The reimbursement for the drugs considered in this dispute is calculated as follows<sup>4</sup>:

- Cyclobenzaprine 5 mg tablets:  $(1.7226 \times 60 \times 1.25) + \$4.00 = \$133.20$
- Acetaminophen/codeine #3 tablets:  $(0.28435 \times 60 \times 1.25) + \$4.00 = \$25.33$

The total reimbursement is therefore \$158.53. This amount is recommended.

---

<sup>1</sup> 28 Texas Administrative Code §133.305(b)

<sup>2</sup> 28 Texas Administrative Code §133.240(q)

<sup>3</sup> 28 Texas Administrative Codes §§133.305(b) and 133.307(c)(1)(B)(i)

<sup>4</sup> 28 Texas Administrative Code §134.503(c)

**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 \$158.53.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$158.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

	Laurie Garnes	November 15, 2018
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 division 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.**