



# 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**

City of Houston

**MFDR Tracking Number**

M4-18-2295-01

**Carrier's Austin Representative**

Box Number 29

**MFDR Date Received**

February 27, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "These medications do not require preauthorization therefore do not need a retrospective review ... Memorial Compounding Pharmacy is not register as an outsourcing facility. Therefore 503A applies and exempts the compounding cream in dispute."

**Amount in Dispute:** \$479.89

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Requestor seeks reimbursement for a drug it provided to the claimant. The drug was determined not to be medically necessary by Respondent's utilization review agent following retrospective utilization review."

**Response Submitted by:** Stone Loughlin Swanson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2017	Meloxicam 100%	\$479.89	\$0.00

### 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**

- 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
- 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical bills.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 216 – Based on the findings of a review organization

- Notes: Refill Denied Per Retrospective Peer Review Determination (MELOXICAM 100%)
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

**Issues**

1. Is the insurance carrier’s reason for denial of payment for the compound in question supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed service?

**Findings**

1. Memorial is seeking reimbursement for Meloxicam 100%, dispensed on August 29, 2017. City of Houston denied the disputed drug with claim adjustment reason code 216 – “Based on the findings of a review organization.”

28 Texas Administrative Code §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.”

28 Texas Administrative Code §133.240(q) states that the insurance carrier is required to comply with 28 Texas Administrative Codes §§19.2009 and 19.2010 when denying payment based on an adverse determination.

Review of the submitted documentation finds that Stone Loughlin Swanson submitted a document dated August 14, 2017 on behalf of City of Houston, as support for a utilization review of the disputed compound. The division concludes that the submitted documentation does not support that City of Houston performed a utilization review in accordance with 28 Texas Administrative Code §19.2009 as it does not address the service in question.

The insurance carrier’s denial reason is therefore not sufficiently supported. The disputed service will consequently be reviewed per applicable guidelines.

2. Documentation presented to the division by Memorial indicates that the billed charges constitute a compound drug. 28 Texas Administrative Code §134.502(d)(2) requires compounds to “be billed by listing each drug included in the compound and calculating the charge for each drug separately.”

The submitted documentation does not support that Memorial listed each drug in the disputed compound, calculating the charge for each drug separately. Therefore, the division concludes that Memorial is not eligible for reimbursement of the compound in question.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
June 22, 2018  
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.**