TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Memorial Compounding Pharmacy

**Respondent Name**
Indemnity Insurance Company of North America

**MFDR Tracking Number**
M4-18-2469-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
March 9, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier denied the reconsideration based on lack of preauthorization or preauthorization was absent. These medications do not require preauthorization therefore do not need a retrospective review."

**Amount in Dispute:** $566.53

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "We have been advised by the adjuster that the denials were not a question of preauthorization. The denial code should have been *Extent of Injury*, which we understand is in the dispute process at TDI. We have therefore updated the current EOB with the correct code."

**Response Submitted by:** myMatrixx

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 26, 2017 | Pharmacy Service – Compound | $566.53 | $566.53 |

## *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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Denied – Medication Not Authorized

**Issues**

1. Did the insurance carrier raise a new defense pursuant to 28 Texas Administrative Code §133.307?
2. Did the insurance carrier maintain its denial of the disputed compound based on preauthorization?
3. Is the requestor entitled to reimbursement for the disputed compound?

**Findings**

1. Memorial Compounding Pharmacy (Memorial) is seeking reimbursement for a compound dispensed on July 26, 2017. In its position statement, myMatrixx argued on behalf of Indemnity Insurance Company of North America, "The denial code should have been *Extent of Injury*, which we understand is in the dispute process at TDI."

   The insurance carrier is required to address only those issues raised before the request for medical fee dispute resolution (MFDR) in its position statement.[1]

   Review of the submitted documentation finds that Indemnity Insurance Company of North America failed to present a denial based on the extent of the compensable injury to Memorial[2] before the date that a request for MFDR was filed.

   The division concludes that this defense presented in myMatrixx's position statement shall not be considered for review because this assertion constitutes a new defense.

2. Indemnity Insurance Company of North America denied the disputed compound stating "Denied – Medication Not Authorized." In its position statement, myMatrixx advised that "the denials were not a question of preauthorization." Therefore, the division concludes that the insurance carrier did not maintain the basis of its denial for the disputed compound. The division will review the dispute based on applicable guidelines.

3. The division concludes that the insurance carrier's denial reasons are not supported. Consequently, the compound in question is eligible for reimbursement.

   The health care provider billed by listing each drug included in the compound and calculating the charge for each drug separately.[3] Each ingredient is listed below with its reimbursement amount.[4] The calculation of the total allowable amount is as follows:

| Ingredient | NDC & Type | Price/ Unit | Total Units | AWP Formula §134.503(c)(1) | Billed Amt §134.503 (c)(2) | Lesser of (c)(1) and (c)(2) |
|---|---|---|---|---|---|---|
| Meloxicam | 38779274601 Generic | $194.67 | 0.18 gm | $43.80 | $35.04 | $35.04 |
| Flurbiprofen | 38779036209 Generic | $36.58 | 4.8 gm | $219.48 | $175.58 | $175.58 |
| Tramadol HCl | 38779237409 Generic | $36.30 | 6.0 gm | $272.25 | $217.80 | $217.80 |
| Cyclobenzaprine HCl | 38779039509 Generic | $46.332 | 1.8 gm | $104.25 | $83.39 | $83.39 |
| Bupivacaine HCl | 38779052405 Generic | $45.60 | 1.2 gm | $68.40 | $54.72 | $54.72 |
| | | | | | Total | $566.53 |

   The total reimbursement is therefore $566.53. This amount is recommended.

[1] 28 Texas Administrative Code §133.307(d)(2)(F)
[2] 28 Texas Administrative Code §133.240
[3] 28 Texas Administrative Code §134.502(d)(2)
[4] 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 $566.53.

## *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 $566.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | Laurie Garnes | July 20, 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**.