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
New Hampshire Insurance Company

MFDR Tracking Number
M4-18-2883-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding is an approved provider and should be reimbursed accordingly."

Amount in Dispute: $840.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the 10/11/2017 medications (Celecoxib 200 mg capsule, Baclofen, Amantadine HCL, Gabapentin USP, Bupivacaine HCL, Amitriptyline HCL) compounded by Memorial Compounding Pharmacy is not owed based on the April 12, 2017 Peer Review from Dr. John Sklar, MD. Dr. Sklar states in the report that 'it is not reasonable to believe that [the injured worker] requires ongoing use of prescription medications and are not supported by the ODG'."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2017	Celecoxib 200 mg Capsules	$284.94	$284.94
October 11, 2017	Pharmaceutical Compound	$555.68	$555.68
	Total	$840.62	$840.62

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:
   - Product/Services Not Covered
   - Duplicate Paid/Captured Claim
   - The provider has billed for the exact services on a previous bill
   - The provider or a different provider has billed for the exact service on a previous bill where no allowance was originally recommended.

Issues

1. Did the insurance carrier raise a new defense in its position statement?
2. Is the requestor entitled to reimbursement for the services in question?

Findings

1. Memorial Compounding Pharmacy (Memorial) is seeking reimbursement for Celecoxib 200 mg capsules and a compound dispensed on October 11, 2017. In its position statement, AIG argued on behalf of the insurance carrier, that "'it is not reasonable to believe that [the injured worker] requires ongoing use of prescription medications…'"

   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 New Hampshire Insurance Company failed to present a denial based on reasonable or necessary treatment to Memorial[2] before the date that a request for MFDR was filed.

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

2. Because the insurance carrier's denial reasons are not supported, the compound in question is eligible for reimbursement. The services in question are covered under 28 TAC §134.503.

   The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately.[3] Celecoxib 200 mg capsules and each ingredient of the compound is listed below with its reimbursement amount.[4] The calculation of the total allowable amount is as follows:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Celecoxib	60505384905	G	$7.58	30	$288.30	$284.94	$284.94
Baclofen	38779038809	G	$35.63	5.4	$240.50	$190.78	$190.78
Amantadine	38779041105	G	$24.23	3	$90.84	$72.69	$72.69
Gabapentin	38779246109	G	$59.85	3.6	$269.33	$204.66	$204.66
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
Amitriptyline	38779018904	G	$18.24	1.8	$41.04	$32.83	$32.83
						Total	$840.62

   The total allowable reimbursement for the compound in dispute is $840.62. This amount is recommended.

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 $840.62.

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[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)

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 $840.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

____________________	Laurie Garnes	August 2, 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.