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
Ysleta ISD

MFDR Tracking Number
M4-18-3019-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
April 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original bill was submitted to carrier on **10/20/2017 via certified mail** … Memorial did not receive any correspondence as per rule so we submitted a Request for Reconsideration … The request was submitted and received by the carrier on **12/07/2017 via certified mail** still with no response."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The initial bill was received by our office on 10/20/17 and was processed on 11/14/17. Charges were based on a Retrospective Review. A reconsideration was received in our office on 12/7/17 and was processed on 12/8/17, maintaining original determination … It is our position denial based on Retrospective Review was appropriate and no reimbursement would be due."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2017	Pharmaceutical Compound	$555.68	$555.68

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 §133.305 sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
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. 28 Texas Administrative Code, Chapter 19 sets out the requirements for utilization review.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization.
   - 723 – Based on a utilization review determination, these charges are denied as not medically necessary and appropriate

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement of the disputed compound?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on October 11, 2017 with the following ingredients:

Ingredient	Amount
Baclofen	5.4 gm
Amantadine HCl	3.0 gm
Gabapentin USP	3.6 gm
Amitriptyline HCl	1.8 gm
Bupivacaine	1.2 gm

Ysletta ISD denied the compound based on medical necessity as determined by utilization review.

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

Claims Administrative Services submitted a document on behalf of Ysletta ISD dated November 14, 2017, to support its denial of the compound in question. The division finds that the submitted document does not support that Ysletta ISD performed a utilization review for the compound considered in this dispute as this document does not address the compound presented in this dispute.

The division concludes that this dispute is not subject to dismissal based on medical necessity.

2. Because the insurance carrier's denial reasons are not supported, the compound in question is eligible for reimbursement in accordance with applicable rules and laws.

The compound in dispute was 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:

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
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
Amitriptyline	38779018904	G	$18.24	1.8	$41.04	$32.83	$32.83
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
						Total	$555.68

The total allowable reimbursement for the compound in dispute is $555.68. This amount is recommended.

[1] 28 Texas Administrative Code §133.305(b)
[2] 28 Texas Administrative Code §133.240(q)
[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 $555.68.

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 $555.68, 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 23, 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.