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
M4-18-3027-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Memorial Compounding has fulfilled the required rule to receive reimbursement."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pursuant to the explanation of benefits, the carrier denied payment for these prescriptions due to utilization review dated 11/27/17 finding the compound medication Meloxicam/Flurbiprofen/Tramadol HCL/Cyclobenzaprine HCL/Burpivacaine HCL dispensed on 10-14/17 based on findings of review organization of not medically necessary; and the absence of notification of preauthorization/authorization."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2017	Pharmaceutical 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 §133.240 sets out the procedures for payment, denial, or reduction of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
4. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.

5. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of the review organization.
   - 197 – Pre-authorization/authorization/notification absent
   - Comments: "UR REVIEW"

Issues

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

Findings

1. Memorial is seeking reimbursement for a compound dispensed on October 14, 2017. New Hampshire Insurance Company denied the compound, in part, based on medical necessity as determined by utilization review.

   Before issuing a denial based on medical necessity, an insurance carrier is required to give the health care provider – in this case, Memorial – an opportunity to discuss the treatment in question.[1]

   Submitted documents do not provide sufficient evidence that Memorial was given an opportunity to discuss the compound prior to the insurance carrier's denial based on medical necessity. Therefore, this dispute is not subject to dismissal based on medical necessity.

2. New Hampshire Insurance Company also denied the disputed compound based on lack of preauthorization. Preauthorization is only required for:

   - drugs identified with a status of "N" in the current edition of the ODG Appendix A;
   - any compound that contains a drug identified with a status of "N" in the current edition of the ODG Appendix A; and
   - any investigational or experimental drug.[2]

   The compound in question does not include a drug identified with a status of "N" in the current edition of the ODG, Appendix A. The insurance carrier failed to raise any other arguments to support its denial based on preauthorization. Therefore, the division concludes that the compound in question did not require preauthorization and the insurance carrier's denial of payment for this reason is not supported.

3. 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:

[1] 28 Texas Administrative Code §133.240(q)
[2] 28 Texas Administrative Code §134.530(b)(2)
[3] 28 Texas Administrative Code §134.502(d)(2)
[4] 28 Texas Administrative Code §134.503(c)

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58	$175.58
Tramadol	38779237409	G	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$104.25	$83.39	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
						Total	$566.53

The total allowable reimbursement for the compound in dispute is $566.53. 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 $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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	August 8, 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.