TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M418-3688-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill for date of service **09/06/2017** was processed and paid incorrectly."

Amount in Dispute: $555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The topical use, in a compound, of baclofen and gabapentin is not supported by the ODG and in fact exceeds the recommendations of the ODG. The requestor's documentation doe not support the use of baclofen and gabapentin in topical form."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 6, 2017	Compound Medication	$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 §133.210 sets out the documentation requirements for medical bills.
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:
   - CAC-16 – Claim/service lacks information or has billing/submission error(s) which is needed for adjudication.
   - CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 784 – Service exceeds recommendations of treatment guidelines (ODG).
   - 874 – Documentation does not support use of medication in topical form.

Issues

1. Is the insurance carrier's reason for denial of payment based on billing errors supported?
2. Is the insurance carrier's reason for denial of payment based on documentation supported?
3. Is the insurance carrier's reason for denial of payment based on treatment guidelines supported?
4. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in dispute?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on September 6, 2017. Texas Mutual Insurance Company (Texas Mutual) denied the disputed compound with claim adjustment reason code 16 – "CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION."

   Review of the submitted pharmacy bills finds no submission or billing errors.[1] The insurance carrier failed to support this denial in its position statement.

2. Texas Mutual also denied the disputed service with claim adjustment reason code 874 – "DOCUMENTATION DOES NOT SUPPORT USE OF THE MEDICATION IN TOPICAL FORM."

   Documentation is not required to be submitted with pharmacy bill.[2] If the insurance carrier requires additional documentation to process the medical bill, the request must:

   - be in writing;
   - be specific to the bill;
   - specifically describe the information to be included in the response;
   - be relevant and necessary for the resolution of the bill;
   - be for information that is part of the injured employee's medical or billing record maintained by the health care provider, in this case, Memorial Compounding Pharmacy;
   - indicate the specific reason for which the insurance carrier is requesting the information; and
   - include a copy of the medical bill requiring the documentation. [3]

   The insurance carrier may request a letter of medical necessity if "the insurance carrier could reasonably support a denial based upon extent of, or relatedness to the compensable injury, or based upon an adverse determination" without the letter of medical necessity.[4] A request for a letter of medical necessity from the prescribing physician must be copied to the billing party, in this case, Memorial Compounding Pharmacy, when the request is made.

   No documentation was found to support that the carrier made an appropriate request for additional documentation or a letter of medical necessity. The Texas Department of Insurance, Division of Workers' Compensation (DWC) concludes that Texas Mutual failed to support this denial reason.

3. Texas Mutual also denied the disputed service with claim adjustment reason code 784 – "SERVICE EXCEEDS RECOMMENDATIONS OF TREATMENT GUIDELINES (ODG)."

[1] 28 Texas Administrative Code §133.10(f)(3)
[2] 28 Texas Administrative Code §133.210(c)
[3] 28 Texas Administrative Code §133.210(d)
[4] 28 Texas Administrative Code §134.502(e)

Prescription drugs that exceed the treatment guidelines may be prescribed and dispensed without preauthorization.[5] When a prescription is dispensed without preauthorization, it is subject to retrospective review.[6] No evidence was found that Texas Mutual performed a retrospective review on the compound in question. The denial for this reason is not supported.

4. Because the insurance carrier failed to sufficiently support its denial of reimbursement, Memorial is entitled to reimbursement.

   The compound in dispute was billed by listing each **drug** included in the compound and calculating the charge for each drug separately.[7] Each ingredient is listed below with its reimbursement amount.[8] 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
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	$555.68

   The total reimbursement is therefore $555.68. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers' Compensation (DWC) 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 DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC 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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 7, 2018 Date

[5] 28 Texas Administrative Code §134.530(d)(2)
[6] 28 Texas Administrative Code §134.530(d)(3)
[7] 28 Texas Administrative Code §134.502(d)(2)
[8] 28 Texas Administrative Code §134.503(c)

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.