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
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-18-3773-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The NDC number provided is a valid NDC number and claim should be processed accordingly."

Amount in Dispute: $702.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medications were determined not to be medically necessary based upon the retrospective review."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2017	Pharmaceutical Compound	$702.68	$702.68

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 940 – Please re-submit with the appropriate NDC number. No AWP for this NDC.
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

Issues

1. Is this dispute subject to dismissal based on medical necessity?
2. Are the insurance carrier's reasons for denial of payment supported?
3. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. Memorial Compounding Pharmacy (Memorial) is seeking reimbursement for a compound that was dispensed on September 15, 2017. In its position statement, the insurance carrier argued, "The Overall Decision on the case is Non-Certified. The medications were determined not to be medically necessary …"

   The dispute response is required to address only those issues raised before the request for medical fee dispute resolution (MFDR).[1]

   Submitted documentation fails to support that the insurance carrier presented a medical necessity denial to Memorial[2] before the date that a request for MFDR was filed. The division finds that this defense raised in Hartford's position statement constitutes a new defense. This new defense shall not be considered for review.

2. The insurance carrier denied the disputed compound with claim adjustment code 16 – "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate." The insurance carrier provided additional remittance advice remarks code 940 to support this denial, which stated, "Please re-submit with the appropriate NDC number. No AWP for this NDC."

   The Texas Department of Insurance, Divisions of Workers' Compensation (DWC) finds that the NDC numbers used to bill for the ingredients of the compound are appropriate as filed. The DWC finds that the insurance carrier's denial of the disputed compound 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:

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
Amatriptyline	38779018904	G	$18.24	1.8	$41.04	$32.83	$32.83
Ethoxy Diglycol	38779190301	G	$0.32	4.2	$1.70	$1.44	$1.44
Versapro Cream	38779252903	B	$3.20	40.8	$142.31	$130.56	$130.56
Fee	NA	NA	NA	NA	$15.00	$15.00	$15.00
						Total	$702.68

   The total allowable reimbursement for the compound in dispute is $702.68. 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 $702.68.

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 $702.68, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	September 28, 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.