



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

Harris County

MFDR Tracking Number

M4-18-3908-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

June 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: \$555.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... the medications were determined not medically necessary to treat the compensable injury upon retrospective review."

Response Submitted by: Thornton, Biechlin, Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 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 (DWC).

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. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.

5. The insurance carrier denied payment with the following claim adjustment reason codes:
 - 197 – Precertification/authorization/notification absent.
 - Notes: “Denied Per Retrospective Reconsideration Peer Review Determination”
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 216 – Based on the findings of a review organization.
 - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Is this dispute subject to dismissal due to medical necessity?
2. Is the insurance carrier’s denial of payment based on preauthorization supported?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Memorial is seeking reimbursement for a compound dispensed on October 6, 2017. The insurance carrier denied the disputed compound, in part, based on a retrospective review for medical necessity. Per submitted explanation of benefits dated October 16, 2017, the pharmacy bill was originally received by the insurance carrier on October 12, 2017. This explanation of benefits did not raise the issue of medical necessity.

Explanation of benefits dated April 17, 2018, denying the compound based on medical necessity is more than 45 days after the date the original complete bill was received.¹

The insurance carrier has the obligation to dispute whether a treatment was necessary within 45 days after receiving a complete medical bill.² The DWC notes that the insurance carrier failed to provide evidence of a denial for medical necessity presented to Memorial within 45 days from the date it received the complete pharmacy bill. Therefore, the DWC finds that the dispute in question is not subject to dismissal based on this denial reason.

2. The insurance carrier denied the disputed compound based on preauthorization. Preauthorization is only required for:
 - drugs identified with a status of “N” in the current edition of the ODG Appendix A³;
 - 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.⁴

The compound in question does not contain an ingredient identified with a status of “N” in the current edition of the ODG, Appendix A.

The determination of a service’s investigational or experimental nature is determined on a case by case basis through utilization review.⁵ Thornton, Biechlin, Reynolds & Guerra provided no evidence that the insurance carrier engaged in a prospective or retrospective utilization review to establish that the specific compound considered in this review is investigational or experimental.

The insurance carrier’s preauthorization denial is therefore not supported.

¹ 28 Texas Administrative Code §133.240(a)

² “A carrier has up to forty-five days from the date it receives a complete medical bill to dispute whether that treatment was necessary.” State Office of Risk Management v. Lawton, 295 S.W.3d 646 (Tex. 2009), <https://caselaw.findlaw.com/tx-supreme-court/1388209.html>

³ *ODG Treatment in Workers’ Comp* (ODG) / Appendix A, *ODG Workers’ Compensation Drug Formulary*

⁴ 28 Texas Administrative Code §134.540(b)

⁵ Texas Insurance Code §19.2005(b)

3. 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.⁶ Each ingredient is listed below with its reimbursement amount.⁷ 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

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 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

November 14, 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 DWC 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.

⁶ 28 Texas Administrative Code §134.502(d)(2)

⁷ 28 Texas Administrative Code §134.503(c)